

DOCTORAL THESIS

'You know, you've got to be kind of human'

How CBT therapists experience personal therapy in clinical practice

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**‘You Know, You’ve Got to be Kind of Human’:
How CBT Therapists Experience Personal Therapy in Clinical Practice.**

by

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**A thesis submitted in partial fulfilment of the requirements for the degree of
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It takes great courage to be human.

‘You Know, You’ve Got to be Kind of Human’:

How CBT Therapists Experience Personal Therapy in Clinical Practice.

ABSTRACT

This study explores the subjective experiences of CBT therapists who have undergone personal therapy and seeks to gain insight into the significance of personal therapy in CBT clinical practice. Seven CBT therapists who have undergone personal therapy were interviewed. Interpretative Phenomenological Analysis (IPA) was chosen to generate rich interview data. Participants were asked about their experience of personal therapy in clinical practice. Participants’ narratives were analysed using IPA to identify common themes. The analysis resulted in twelve interrelated themes from which three master themes emerged. The first theme, ‘Personal therapy creates conflict’, explores a paradox that arises between personal therapy and CBT clinical practice; participants suggest that personal therapy equips them with therapeutic tools that paradoxically hinder their capacity to practice a standardised protocol-led CBT. The second master theme, ‘Personal therapy ties me to humanity’, suggests that the gap between personal therapy and CBT practice narrows by participants’ ‘use of self’: calling upon their own vulnerabilities to forge fundamental connections with their clients based on the shared experience of being human. This study finds that all participants value ‘being human’ with their clients, however, struggle to find the space ‘to just be’ within an action-focused, goal-orientated CBT model. This is further explored in the final theme, ‘Personal therapy: Being and doing’. Potential implications of the themes that emerged were considered. This study contributes to the literature on CBT and counselling psychology, and to the understanding of a divide in the psychotherapy profession between evidence-based priorities and expectations of reflective practice.

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INTRODUCTION

Navel-gazing. A term that is often thrown at therapists to caution them against participating in excessive introspection at the expense of their clients. I was first introduced to the notion of navel-gazing in response to my research topic: why was I focusing on therapists' perspectives rather than on clients' perspectives? The fact that my participants *are* clients seemed irrelevant and dismissed by the fact that they are also therapists. This use of the term navel-gazing extends beyond a caution against self-indulgence and appears to undermine therapists' perspectives by dismissing their position as clients, which I believe is an invaluable perspective. I was perplexed by the paradoxes that this notion presented: Are clients navel-gazers? Does being a therapist mean not needing therapy? Would you want to receive therapy from someone who has not had any therapy themselves?

My perplexity resonates with my role as a counselling psychologist and my reflexive position in both therapeutic practice and research. Reflexivity represents the idea that 'the observer and observed cannot be separated' (Donati, 2016, p.67). Reflexivity helps to manifest a reciprocal relationship that underpins all aspects of the counselling psychology profession (Kasket, 2012). Furthermore, reflexivity is an essential facet of qualitative research paradigms that recognise the centrality of the researcher's subjectivity, understanding, and meaning-making to the research process (Donati, 2016; Shaw, 2010). In line with the role of reflexivity in counselling psychology and qualitative research, it seems appropriate to introduce the reader to my research project through a personal, reflexive statement.

I initially became interested in the field of counselling psychology during my own experience of personal therapy years ago, which I then continued throughout my training. However, when I started working within the National Health Service (NHS) Improving Access to Psychological Therapies (IAPT) services I was surprised to find that, whilst my colleagues had years of clinical experience, most had never had personal therapy themselves. This sparked my interest in therapists' work with vulnerable people and how personal therapy can be useful. I began to think about how my personal therapy influences my clinical practice. I started to notice when I would become aware of my own personal therapy in clinical practice. I felt that personal therapy facilitated therapeutic relationships, particularly when working with clients' issues that touched on my own. But finding the words to describe how it was useful remained difficult.

The topic of personal therapy in clinical practice has been a focus of consideration for over a century and has gradually developed into a controversy over whether the use of personal therapy amongst psychotherapists is beneficial and, even, necessary. An overwhelming body of research suggests that personal therapy is beneficial by enhancing professional development and relational capacities and decreasing chances of burnout and unethical behaviour. Today, personal therapy has become an integral element of most psychotherapy trainings. However, it remains peripheral to Cognitive-Behavioural Therapy (CBT) training.

CBT is the only evidence-based psychotherapy intervention recommended for both depressive mood and anxiety disorders and, therefore, has become the most commonly provided treatment within the NHS. Whilst personal therapy is considered

essential in most trainings, it is not considered essential in CBT training. This appears to be part of a prevailing political culture within the field that seems to dismiss the therapist's subjective perspective in place of formulaic solutions and appears to be affecting training and the latest generation of therapists without the opportunity to be questioned. CBT has a particular resonance at the moment, where the focus on procedures and treatment strategies can too easily be prioritised over a human connection, in which an intersubjective relationship between therapist and client is formed and developed. I aim to add to the literature by exploring the perspective of CBT therapists, a popular, yet under-researched group on the topic of personal therapy.

Further in line with the reflexive nature of this project, it seems appropriate to offer the reader a deeper account of my personal motivation to explain my interest in developing this research. As a counselling psychologist, I have been trained with a relational foundation and hold a sense of responsibility to balance my subjective perspective with formulaic solutions; to marry the relational with scientific elements of psychotherapeutic practice. However, with this I have struggled. A split in the psychotherapy profession has emerged between reflective and evidence-based practices and the division of counselling psychology appears to straddle this growing division. Navel-gazing is somewhat symptomatic of this split; as if therapists should have therapy but also dismiss it. In my attempt to understand how 'the scientific demand for rigorous empirical enquiry' can be married to 'a firm value base grounded in the primacy of the therapeutic relationship' (Division of Counselling Psychology, 2015a, p.1), I was drawn to ask CBT therapists who have had personal therapy about how they might balance the relational with the scientific.

The divide between ready-made solutions and human connection can be considered another symptom of a split in the psychotherapy profession that lies within the scientific paradigms, between quantitative and qualitative research. Curiously, I find that much of the research on the topic of personal therapy has adopted a quantitative approach, incorporating Likert scales and other 'objective' measures to assess the impact of personal therapy on clinical practice. Despite the many positive results, the literature struggles to determine whether personal therapy results in better clinical outcomes, in part due to the subjective and equivocal nature of the clinical experience. Rather than continue to try to prove this elusive link, perhaps it is more appropriate to ask therapists themselves about how they use personal therapy in their clinical practice. Therefore, I adopted a qualitative approach where semi-structured interview schedules have allowed participants greater scope to express the ways in which they make sense of their experiences, for a direct exploration of whether and how personal therapy might be useful to CBT clinical practice. I offered participants a way to convey what they have gone through, which, in exchange, offered me a way to consider and grasp what their experiences mean to them. I analysed participants' accounts using Interpretative Phenomenological Analysis (IPA), which allowed me to produce theoretical frameworks based on and transcending this individual meaning making.

This phenomenological approach seems to be at odds with the prevailing political culture, which prioritises a positivist approach to obtaining objective solutions over the subjective discovery of personal insight. In contrast to phenomenology, positivism is a deductive approach that depends on quantifiable observations to determine logic and facts (Ponterotto, 2005). These differences further seem to exemplify a split in the

profession that lies between what you see and what you don't, body and soul, evidence and reflection; seeming dichotomies embedded within this research project that perhaps more appropriately prevail on a continuum.

Within our culture, there is a seductive idea of a ready-made solution, the safety of knowing, which, in my experiences as both therapist and client, does not seem to mean much unless you have a human person caring about you. Learning how CBT therapists use personal therapy to inform their clinical practice may narrow the contradiction between the evidence-based priorities of the CBT model and its expectations of reflective practice; by offering a research-based understanding of how CBT clinicians incorporate self-awareness and interpersonal relatedness within their therapeutic work.

This study explores CBT therapists' experiences of personal therapy in clinical practice. The next chapter reviews the existing literature on the topic of personal therapy and the current context of increasing interest in the CBT, IAPT and positivist models of therapeutic practice. This is followed by detailed consideration for the interpretative and phenomenological methodology upon which this research project is based. The analysis of participants' accounts is presented before inviting the reader into a discussion of what I learned from participants' accounts and its clinical implications for CBT, the field of counselling psychology and the prevailing political culture.

LITERATURE REVIEW

The existing literature on the topic of personal therapy and psychotherapeutic clinical practice is vast. ‘Psychotherapist’ is an equally vast umbrella term that refers to trained therapists of various therapeutic approaches, including CBT. ‘Personal therapy’ refers to the psychotherapy undergone by such trained therapists and is generally considered an integral part of psychotherapists’ professional training and clinical practice. Yet, personal therapy has rarely, if ever, been formally encouraged in CBT training.

Personal therapy has been linked to reducing the likelihood of blind spots and unethical behaviour in clinical practice as well as to the enhancement of psychotherapists’ self-awareness and interpersonal relatedness, identified in the literature as major contributors to therapeutic outcomes. There have been a number of studies attempting to explore the role and impact of personal therapy in the clinical practice of psychotherapists of various theoretical orientations. However, CBT therapists have received scarce attention.

Whilst more traditionally emphasised in other therapeutic approaches, CBT, too, demands a high degree of self-awareness from the psychotherapist, especially in the context of working with clients with long-standing, complex problems. Furthermore, CBT shares with other psychotherapeutic approaches the central component of a collaborative relationship. Given the frequently cited research linking the role of the therapeutic relationship and the therapists’ self-awareness to clinical outcome, I argue

that more attention be paid to the role of personal therapy in the practice of CBT therapists.

In this chapter, the notion of psychotherapy is considered before reviewing the existing literature on the use of personal therapy in general clinical practice and CBT. This is followed by a review of the current context of increasing interest in the CBT model as it relates to the development of the medical model and manualised therapies within NHS IAPT services. The literature on the use of personal therapy in clinical practice is then revisited through a dichotomous lens, between positivist and phenomenological perspectives. Lastly, conclusions and the research question are addressed.

What is Psychotherapy?

The NHS defines psychotherapy as ‘a type of mental health therapy used to treat emotional problems and mental health conditions’, and describes psychotherapists as the trained professionals who listen to a person’s problems and help that person to discover the source of a problem to find a solution (<http://www.nhs.uk/conditions/Psychotherapy>). Holmes’ (2000) more expressively illustrates psychotherapy as the facilitation and strengthening of our personality to enhance our sense of autonomy and capacity to form greater intimate relationships. This definition signifies the psychotherapist’s position as a facilitator to enhance self-awareness, interpersonal awareness, and sense-making. In psychotherapy, our thoughts and worries are meant to be listened to in detail and taken seriously, to help us find meaning or coherence in what we find overwhelming and unmanageable (Richardson & Hobson, 2000). To offer this service to others, most psychotherapists are trained to tune into their own

narrative style as well as to the various narrative styles of their clients (Richardson & Hobson, 2000), exemplifying its overarching value on individuality and uniqueness.

The emotional component

People who are emotionally distressed usually seek psychotherapy as a process to recollect, explore, understand and change themselves (Whelton, 2004). Research supports that the exploration and expression of one's pain, loss and trauma, and the development of emotional experience into meaningful narratives, can improve psychological health (Booth & Pennebaker, 2000; Pennebaker, 1997; Pennebaker & Seagal, 1999). One of the most significant and consistent findings in the literature of the psychotherapeutic process is that 'depth of experiencing', one's capacity to readily access emotions to form new meanings and solve problems, is positively correlated with therapeutic outcome (Goldman, Greenberg & Pos, 2005; Klein, Mathieu-Coughlan & Kiesler, 1986; Orlinsky & Howard, 1978). Therefore, a prominent aspect of the therapeutic process is the arousal and transformation of emotion (Honos-Webb, Surko, Stile & Greenberg, 1999; Stalikas & Fitzpatrick, 1995). Castonguay, Goldfried, Wiser, Raue and Hayes (1996) further present a theoretical argument that supports emotional processing as essential to therapeutic change, regardless of the therapeutic approach. However, different therapeutic approaches conceptualise emotions differently.

For example, the psychodynamic approach has long considered emotion to be an expression of a complex, ambivalent and conflicted inner motivational and relational world that must be acknowledged, faced and tolerated within the therapeutic relationship (Greenberg & Mitchell, 1983; Sandler & Sandler, 1978; Stein, 1991;

Westen & Gabbard, 1999). In contrast, CBT has traditionally viewed emotion as symptomatic, troublesome and something to be tamed under rational control (Samoilov & Goldfried, 2000). Wiser and Goldfried's (1993) study compared the role of emotion in the process of psychotherapy in psychodynamic-interpersonal and cognitive-behavioural therapies. Results indicated that affective experiencing was equally present in the two orientations. However, therapists' clinical views of the role of emotion were dissimilar. Psychodynamic-interpersonal therapists viewed higher emotional arousal as more critical to the change process, whereas CBT therapists shared the view that lower levels of emotional arousal were more therapeutically significant. However, cognitive experts today challenge this conviction. CBT is becoming increasingly open to a more complex and differentiated view of the relationship between cognition and emotion (see Leahy, 2002). Overall, across theoretical approaches higher levels of emotional arousal predict better outcomes, yet it is dependent upon a strong working alliance (Beutler, Clarkin & Bongar, 2000; Iwakabe, Rogan & Stalikas, 2000; Mergenthaler, 1996; Whelton, 2004).

The relational component

Greenson (1967) coined the term 'working alliance' to describe one of the essential components of therapeutic success: a positive collaboration between client and therapist. However, the significance of the therapist-client relationship on the outcome of psychotherapy dates back to Freud (1913/1958) and has become one of the oldest themes in therapy research. Interest was maintained through the writings of Sterba (1934), Zetzel (1956) and Gitleson (1962), and was also reformulated by Carl Rogers (1957) and his associates (i.e. Barrett-Lennard, 1962) to focus on the therapist's capacity to be empathic, congruent and to offer their clients an

unconditional positive regard.

Initially a psychoanalytic concept, the therapeutic alliance had spread into a more general therapeutic notion, and a significant indicator of therapeutic outcome, generalizable to all psychotherapeutic approaches (Bordin, 1979; Gelso & Carter, 1985). For example, Horvath and Symonds's (1991) meta-analysis of 24 studies related the quality of the working alliance to the therapeutic outcome and identified the therapeutic alliance as a significant variable linking therapy process to outcome amongst all therapeutic approaches. Reandeu and Wampold (1991) more specifically examined the therapeutic alliance in brief-therapy cases and found therapists' roles to be inherently powerful regardless of a 'high' or 'low' alliance. However, client participation was positively correlated with the therapeutic alliance, which previous research had shown to be highly correlated with therapeutic outcome (see Gomes-Schwartz, 1978; Hartley & Strupp, 1983; Kokotovic & Tracey, 1990; Moras & Strupp, 1982; O'Malley, Suh & Strupp, 1983; Strupp, 1980a, 1980b; Strupp & Hadley, 1979).

The central idea of the therapeutic alliance focuses on the collaboration between, and capacities of both, the therapist and client to negotiate a contract appropriate to the type of therapy (Bordin, 1980; Horvath & Greenberg, 1989; Luborsky, 1976; Marmar, Weiss & Gaston, 1989; Marziali, 1984; Strupp & Hadley, 1979). Much of the research literature focuses on investigations of the impact of the alliance on psychodynamic, experiential and cognitive therapies (Greenberg & Webster, 1982; Luborsky, 1976; Rounsaville, Chevron, Prusoff, Elkin, Imber, Sotsky & Watkins, 1987). These distinct therapeutic approaches can be bound together by a shared

emphasis on the therapist-client relationship; conceptualised as a vital context of personality change within the psychodynamic model; as a supportive and growth-facilitating influence within the existential model; and as a precondition for the effective delivery of CBT interventions (Orlinsky, Geller & Norcross, 2005).

Personal Therapy and Clinical Practice: An Overview

Personal therapy for psychotherapists has been a focus of consideration for over a century. Freud (1912/1958) first proposed personal therapy as an integral element of professional development amongst psychoanalysts. This has gradually developed into a controversy over whether the use of personal therapy amongst all psychotherapists is beneficial and, even, necessary (Buckley, Karasu & Charles, 1981; Fierman, 1965; Holt & Luborsky, 1958; McNamara, 1986).

An overwhelming body of research suggests that psychotherapists of all theoretical orientations who have had personal therapy find that it enhances professional and personal development and relational capacities (Farrell, 1996; Geller, Norcross & Orlinsky, 2005). Norcross, Strausser-Kirtland and Missar (1988) reviewed earlier sources (i.e. Fleischer & Wissler, 1985; Fromm-Reichmann, 1959; Garfield & Kurtz, 1976; Shapiro, 1976; Wampler & Strupp, 1976) and summarised that personal therapy contributes to clinical practice by improving the emotional and mental functioning of the therapist; providing the therapist-client with a more complete understanding of their interpersonal dynamics; alleviating the emotional stresses and burdens of working clinically; serving as a profound socialisation experience; facilitating the internalisation of the healer role; placing the therapist in the role of the client;

increasing respect for client struggles; and providing a first-hand intensive opportunity to observe clinical methods, all of which are integral training goals.

Many therapists find personal therapy to be the most significant part of their training (Macran & Shapiro, 1998). Yet, it has also been suggested that a mandatory element of personal therapy in training can have a negative impact on the trainee who becomes preoccupied with their own emotional turmoil (Strupp, 1958, 1973; Garfield & Bergin, 1971; Greenberg & Staller, 1981). Thorne and Dryden (1991) highlight the obligation of personal therapy in training as a guarantee for a systematic and thorough confrontation of the trainee's personal issues. However, there is also concern that the lack of choice hinders its potential efficacy. Another argument is that a mature, well-balanced trainee could suffice with a competent clinical supervisor, and find personal therapy unnecessary (Altucher, 1967; Glass, 1986; Leader, 1971; Traux & Carkhuff, 1967). In fact, many psychotherapists choose not to undertake personal therapy, citing their own coping strategies sufficient to maintain their wellbeing (Norcross, Bike, Evans & Schatz, 2008). Many psychologists, however, report undergoing personal therapy for the purpose of managing mild 'personal stuff' and to enhance mental wellbeing (Norcross, 2005), not to achieve a training goal or attain a specific technique (Norcross, Strausser-Kirtland & Missar, 1988), but perhaps simply to be a part of the client experience.

The research literature has also identified null or negative effects of personal therapy on psychotherapists. Four studies (Buckley et al., 1981; Grunebaum, 1986; Norcross et al., 1988; Pope & Tabachnick, 1994) that asked participants whether personal therapy had been harmful in any way showed that eight to 22 percent of participants

responded affirmatively. Buckley et al. (1981) speculated that unresolved conflictual transference feelings are indicated in harmful therapeutic experiences. Grunebaum (1986) found that 'harmful' therapeutic experiences cluster under five themes: distant and rigid therapists; emotionally seductive therapists; poor client-therapist match; explicitly sexual therapists; and dual relationships with the therapist. In a separate study, Pope and Tabachnick (1994) identified therapists' sexual or attempted sexual acts, incompetence, sadistic or emotionally abusive behaviour, general failure to understand the client, and nonsexual dual relationships and boundary violations, as what causes the most harm. These are unfortunate but realistic insights into the potential dangers of engaging in an intimate therapeutic encounter; dangers from which psychotherapists are ethically bound to protect their clients and, perhaps, serves to support the use of personal therapy amongst psychotherapists: to diminish the chance of such dangers from occurring in their clinical practice.

Due to clients' heightened vulnerability, the therapeutic relationship can be more easily damaged by moments of misunderstanding or intemperate emotional expression (Bellah, Madsen, Sullivan, Swidler & Tipton, 2007; Schneider, 1980). The personal therapy undertaken by psychotherapists can be the means for developing, refining and maintaining interpersonal qualities and skills at the highest level (Orlinsky, Geller & Norcross, 2005). For example, Pope and Tabachnick (1994) also found common benefits of personal therapy to include enhanced self-awareness and self-understanding, developed self-esteem and improved clinical skills. An overwhelming amount of research suggests that personal therapy significantly serves to enhance aspects of clinical practice that seem to extend beyond what can be learned to, arguably, what must be experienced: such as self-awareness of personal issues,

values, conflicts and defence mechanisms; increased empathy and interpersonal relatedness; and decreased chances of burnout and unethical behaviour (Bellows, 2007; Macran & Shapiro, 1998; Norcross, 2005; Orlinsky, Norcross, Rønnestad & Wiseman, 2005; Orlinsky, Schofield, Schroder & Kazantzis, 2011; Rake & Paley, 2009; Rizq & Target, 2008a, 2008b, 2010; Wiseman & Egozi, 2006; Wiseman & Shefler, 2001).

Overall, many psychotherapists—approximately three quarters (Norcross & Guy, 2005), report making use of personal therapy throughout the course of their professional careers (Orlinsky, Schofield, Schroder & Kazantzis, 2011) and find it both personally and professionally beneficial (Geller, Norcross & Orlinsky, 2005; Macran, Stiles & Smith, 1999; Norcross, 2005; Orlinsky, Norcross, Rønnestad & Wiseman, 2005). Yet, the proponents of different theoretical models assign various values and purposes to personal therapy (Malikiosi-Loizos, 2013). A US study by Norcross, Karpiak, and Santoro (2005) found that out of 646 clinical psychologists, 100 percent of psychoanalytic therapists, 81 percent of psychodynamic therapists, 76 percent of humanistic therapists, 65 percent of cognitive therapists, and 64 percent of behaviour therapists, had undergone personal therapy. Other international studies have revealed similar patterns. Orlinsky, Rønnestad et al. (2005) conducted a study of therapists around the world and found that 92 percent of psychodynamic therapists, 92 percent of humanistic therapists and 60 percent of CBT therapists had undergone personal therapy. It might come as no surprise that the use of personal therapy is most popular amongst psychoanalytic/psychodynamic therapists, then humanistic therapists and, least, amongst CBT therapists.

Within the United Kingdom Council for Psychotherapy (UKCP) all 80 member organisations have extensive personal therapy training requirements, except for one: members of behavioural and cognitive psychology. The CBT model's traditional focus on specific therapeutic techniques to promote psychological change rather than on the relationship between client and therapist has served to downplay the role of the CBT therapist's self-awareness (Rizq, 2010a). Meanwhile, the current position of personal therapy in counselling psychology is underpinned by the emphasis of self-awareness in training and on the use of the self of the therapist in clinical practice (Rizq, 2010a). In fact, within the British Psychological Society (BPS), it is only members of the Division of Counselling Psychology that are required to undergo a mandatory period of personal therapy during training. The BPS (2015b) supports the use of personal therapy to develop greater self-awareness through the understanding of personal therapy from the perspective of a client; to understand therapy through one's own life experience; and to be able to critically self-reflect on one's use of self in the therapeutic processes. Counselling psychologists are required to maintain 'a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics in the therapeutic context' (BPS, 2015c), which is potentially relevant across all the theoretical models they practice (including CBT).

A brief psychodynamic perspective

Freud first posed the question how one could guide another through a process of self-knowledge without having first gained awareness of his or her own hidden thoughts and desires. According to the psychodynamic model, personal therapy is thought to bring to light one's internal subjective states, unconscious motivations, expressions of emotions and past experiences (Lorr & McNair, 1964; Sundland & Barker, 1962), as

well as to enhance self-awareness and one's capacity to manage countertransference reactions (Kumari, 2011). This is especially relevant to psychoanalytic oriented psychotherapists, whose focus is on acknowledging and confronting primitive conflicts through the revelation of unconscious needs and desires, which requires them to deal with both their clients' as well as their own unconscious process, to reduce blind spots and facilitate the client's therapeutic progress (Orlinsky, Geller & Norcross, 2005).

A brief humanistic perspective

The humanistic approach is based on the belief that as humans we possess an internal need and potential for growth, which is always present and creates a basis for therapeutic change (Malikiosi-Loizos, 2013). This philosophy of growth is built upon the significance of self-awareness, openness to one's experience, and one's lifetime's task to actively work on oneself, and is shared between therapist and client (Mearns, Thorne & McLeod, 2013; Rice & Elliot, 1996). Therefore, the psychotherapist's commitment to the personal growth of their clients must be matched by their own commitment to personal growth (Orlinsky, Geller & Norcross, 2005). Furthermore, personal therapy is seen to enhance the psychotherapist's capacity to offer clients the core conditions of empathy, congruence and unconditional positive regard, upon which the person-centred approach is based. The humanistic approach prizes the therapist's 'use of self' as the most important aspect of treatment, which depends on the therapist's capacity to acknowledge and distinguish their own unique feelings, beliefs and values from that of their clients, and to cultivate a relationship where clients feel accepted and equal (Mearns, Thorne & McLeod, 2013). Wiseman and Shefler (2001) suggest that personal therapy plays an important role in the therapist's

ongoing process of individuation and in the development of the ‘use of self’, to achieve authentic relatedness with clients.

A CBT perspective

Unlike the psychodynamic and humanistic approaches, the behavioural origins of CBT and the philosophy of science upon which it is based have greatly influenced its focus on the reduction of problematic cognitions and behaviours with well-defined and validated scientific techniques (Beck, 1967). The arrival of cognitivism in the 1960s joined the behavioural movement and placed the study of human learning and cognitive knowledge at the centre of empirical psychological research. The study of ‘automatic negative thoughts’ (Beck, 1967) identified how certain errors of cognition and maladaptive reaction patterns could be changed (Beck, 1993).

CBT was initially established as a form of psycho-education, where therapists teach clients techniques to change attitudes, behaviours, and cognitions (Malikiosi-Loizos, 2013). Its traditional focus on the amelioration or removal of specific symptoms, and the correction of irrational beliefs and faulty reasoning that give rise to symptoms, gives little reason to formally recommend personal therapy for therapists who do not currently experience overt symptoms (Orlinsky, Geller & Norcross, 2005).

Furthermore, as the antithesis of working with the unconscious, this learning experience does not generally expect its therapists to be aware of their own nor their clients’ unconscious feelings and fantasies (Laireiter & Willutzki, 2005).

Nevertheless, CBT has increasingly begun to recognise the significance of the psychotherapist’s interpersonal behaviour with clients (Orlinsky, Geller & Norcross, 2005), especially regarding the therapist’s capacity for self-knowledge. The notion of

‘self-knowledge’ within the CBT model refers to the relational domain of personal and interpersonal sensitivities: to develop skills that support the therapeutic relationship, such as of empathy and of identifying inappropriate feelings towards a client (Bennett-Levy & Thwaites, 2007; DiGuiseppe, 1991; Malikiosi-Loizos, 2013).

Although not formally encouraged, research shows that many CBT therapists do undergo personal therapy. In the United States, about 50 to 60 percent of CBT therapists engage in personal therapy at least once in their lives (Geller, Norcross & Orlinsky, 2005). Laireiter (2000) conducted a similar study in Germany and further found that about 50 to 60 percent of CBT therapists who undergo personal therapy prefer psychodynamic psychotherapy, compared to about ten to 15 percent who prefer to undergo their own CBT. To date, no such studies have been conducted in the UK.

Nonetheless, there has been a recent emphasis on the emotional and interpersonal experiences of CBT therapists (Haarhoff, 2006). It has been suggested that CBT demands a high degree of self-awareness from its psychotherapists (Wills & Sanders, 1997); and is of particular significance amongst cognitive therapists who work with clients with long-standing, complex problems (Beck & Freeman, 1990; Linehan, 1993). Beck and Butler (2005) encourage personal therapy as an appropriate method of reflection within clinical practice. Although personal therapy does not have a long or deep tradition in CBT, it is increasingly becoming accepted as a helpful way to improve clinical practice (Geller, Norcross & Orlinsky, 2005).

Current research shows that personal therapy has overwhelming positive clinical implications (Orlinsky, Schofield, Schroder & Kazantzis, 2011; Rake & Paley, 2009;

Rizq, 2011; Rizq & Target, 2008a, 2008b, 2010), yet there has been little interest to date on how it relates to CBT clinical practice. Whilst most European countries require an obligatory number of hours of personal therapy in order to become accredited or licensed as a psychotherapist (Geller, Norcross & Orlinsky, 2005), this does not apply to CBT therapists within the UK. However, in other European countries where government regulations on psychotherapy similarly exist (Austria, Germany, Switzerland, the Netherlands, Ireland and Finland), personal therapy is mandatory in becoming an accredited psychotherapist of any orientation within the health care system, including CBT (Laireiter & Willutzki, 2005).

Orlinsky, Schofield, Schroder & Kazantzis (2011) conducted a large quantitative study with just about 4,000 psychotherapists across six English-speaking countries (United Kingdom, Republic of Ireland, United States, Canada, Australia and New Zealand) on the use of personal therapy in clinical practice. The highest prevalence of psychologists who had never undergone personal therapy was in the United Kingdom at 35 percent. Orlinsky et al. (2011) suggested this may be attributed, in part, to the comparatively greater salience of the CBT model in the UK. Since the initiation of IAPT, CBT has become the most popular therapeutic orientation in the UK and remains the focus of NHS mental health services. Clinical psychologist trainees are employees of the NHS and are predominantly trained in the CBT model. They, like their CBT contemporaries, are not formally encouraged to undergo personal therapy. The BPS Division of Clinical Psychology (2015) states on its website that “the difference in requirements [between the Divisions of Counselling and Clinical Psychology] is historical and also due to the foundation upon which each of the programmes was developed” (Personal Therapy section).

The Rise of IAPT

The NHS was founded in 1948 as part of “a revolutionary plan to bring quality healthcare” to all UK citizens (Sreenan, 2013, p. 22). Its structure was established within the medical model and gave the medical profession a large influence over budget and the delivery of mental health care, which consequently served to medicalise social support (Ham, 2009; Sreenan, 2013). Ascribing to the medical model, a focus has been placed on pathologising mental health issues and developing ways in which they can be ‘cured’ most efficiently and cost-effectively (Layard, Bell & Clarke, 2006).

Significant political differences exist between the medical model of mental health and other therapeutic models (Sreenan, 2013), a trend that has been said to have started in post-second World War America (Addis, Cardemil, Duncan & Miller, 2006).

Psychologists have been encouraged to take on more of a ‘scientist-practitioner’ role, incorporating the medical language into a notion of ‘mental disease’, which has now led to the use of drug evaluation methods, such as the Randomised Control Trial (RCT), in mental health treatment research. Sreenan (2013) explains how in 1999 the Department of Health prioritised five types of research evidence, hierarchically, to constitute knowledge in the field of healthcare provision: systematic reviews with at least one RCT, a minimum of one RCT, a quantitative study without randomisation, an observational study and, lastly, the opinion of experts, service users and carers. As the medicalisation of mental health increases, along with the ‘gold standard’ of RCT research, a relationship between the two has evolved (Sreenan, 2013).

The medical model of mental health

In 1952 the psychologist Hans Eysenck made a bold claim warning the NHS against the hypothesis that psychotherapy facilitates wellness and, instead, suggested that it is no more effective than spontaneous remission. The psychiatrist, Michael Shepherd (1979, 1984), furthered the claim that psychotherapy is ineffective by suggesting that it might even be harmful, and in 1984 strikingly likened a psychotherapist's effectiveness with that of a placebo pill. He came to this conclusion following the Prioleau, Murdoch, and Brody (1983) review of outcome studies.

Bloch and Lambert (1985) later criticised Shepherd's (1984) editorial for its distorted lack of objectivity and disregard for the (Prioleau, Murdoch & Brody, 1983) review's several weaknesses. Bloch and Lambert (1985) went on to identify many well-founded and relevant reviews of the literature on psychotherapeutic outcomes that Shepherd (1984) had neglected (i.e. Andrews, 1983; Andrews & Harvey, 1981; Dush, Hirt & Schroeder, 1983; Landman & Dawes, 1982; Miller & Berman, 1983; Nicholson & Berman, 1983; Shapiro & Shapiro, 1982; Smith & Glass, 1977). One of the neglected studies by Smith and Glass (1977) offered convincing evidence of the efficacy of psychotherapy in which clients were found to be better off than 75 percent of untreated individuals. This study was later critically reanalysed by Landman and Dawes (1982) who verified the positive conclusions of therapeutic efficacy.

Andrews and Harvey (1981) conducted a reanalysis of 475 controlled studies and similarly found that the condition of clients after psychotherapeutic treatment was better than that of 77 percent of untreated controls measured at the same time. This study further identified behaviour and psychodynamic therapies as superior to other

psychotherapeutic approaches. Miller and Berman (1983) later reviewed the research evidence for CBT, specifically, and were inconclusive about whether CBT is superior to other psychotherapies. However, the efficacy of CBT appeared relatively uniform across diagnostic categories and equally effective when administered in a group or individual format.

Aaron T. Beck (1967) indeed hoped that the success of CBT would be its ability to be manualised and replicated by other therapists: “The same therapeutic program used by different therapists does not differ substantially from one to the other” (p. 333).

Sreenan (2013) finds that, “In general, studies tend to equate competence with technical skills and adherence to specific models rather than a broader sense of the word” (i.e. relational competence, emotional competence, etc.) (p.44). Perhaps this is due to technical adherence being easier to monitor or rate than other aspects of competence, and directly serves the overriding goal of NHS psychological services: to provide evidence-based treatments in the most cost-efficient way.

Cost-efficiency and mental health

Early findings suggested that psychotherapy would be economically beneficial for the UK. For example, the Yates and Newman (1980a, 1980b) review of American cost-effectiveness studies of psychotherapy found that medical services were over utilised, such as when clients with physical symptoms associated with psychiatric conditions were treated for the physical rather than psychiatric symptoms (McGrath & Lowson, 1986). Schlesinger, Mumford, and Glass (1981) and Mumford, Schlesinger, Glass, Patrick, and Cuerdon (1984) later reviewed the evidence and found that psychotherapeutic services were both effective and reduced the utilisation of medical

services by up to 20 percent. McGraw and Lowson (1986) also examined the concurrent debates, of the doubts about (Gwyn Jones, 1985; Shepherd, 1984; Wilkinson, 1984) and defences of (Aveline, 1984; Bloch & Lambert, 1985) psychotherapy services within the NHS and concluded that psychotherapy has beneficial effects that can be economically justified within the NHS.

In 2000, the Psychiatric Morbidity Report (Office of National Statistics, 2001) identified depression, with or without anxiety, to be the most prevalent form of mental disorder in the UK. In 2005, Lord Richard Layard's presentation, "*Mental health: Britain's biggest social problem?*", highlighted the economic cost of depression and anxiety, mainly in that it reduced 'output' through sick-leave and unemployment. Layard, Bell & Clarke (2006) suggested that making psychological therapies available to everyone in Britain would pay for itself by reducing expenditure on incapacity benefits to people able to go back to work. In October 2007, the UK government announced their initiative to Improve Access to Psychological Therapies (IAPT) for depressive mood and anxiety disorders within the NHS with a focus on increasing employment.

CBT as a manualised therapy

However, the economic downturn (i.e. increased unemployment and other fallout from the recession) increased the demand for mental health services and reduced funding levels for public sector services (Royal College of Psychiatrists, NHS Confederation Mental Health Network & London School of Economics and Political Science, 2009). The IAPT movement called further attention to the political culture's sense of urgency for evidence-based psychological therapies to be made more

available by improving access to primary care mental health services. The proposal was driven by the focus on how mental health issues could be treated effectively and economically by ascribing to the dominant medical model (Layard et al., 2006). In 2004 the National Institute for Health and Care Excellence (NICE) initiated systematic reviews of the effectiveness of a variety of therapeutic interventions for depressive mood and anxiety disorders, which led to the publication of a series of clinical guidelines (NICE 2004a, 2004b, 2005a, 2005b, 2006, 2009a, 2009b, 2011) that strongly supports the use of certain psychological therapies, predominantly CBT. Thousands of new psychological therapists were trained by the NHS and employed in IAPT clinical services to offer psychoeducation, guided self-help, and psychotherapy based on cognitive behavioural principals (Clark, 2011).

The need to improve effectiveness without increasing costs, along with the rising demands for talking therapies and a lack of trained therapists, resulted in the further development and evaluation of manualised protocols and guided self-help in the form of computer-based CBT (Goldberg & Gournay, 1997; Layard et al., 2006).

Richardson and Richards (2006) argued that CBT-based self-help materials were limited in value as they lacked the common ingredients of personal therapeutic encounters. However, the implications of Learmonth and Rai's (2008) study to determine whether an established computer-based CBT programme (*Beating the Blues*) could extend beyond primary care surprisingly found that outcomes from computerised CBT offered in routine care were comparable to those observed from face-to-face CBT. Another study (Reger & Gahm, 2009) conducted a meta-analysis of 19 RCTs of treatment for anxiety disorders and found that outcomes of computer-based CBT were similar to outcomes of traditional face-to-face CBT. The success of

computer-based therapies challenges the claim that a relational component of therapeutic practice is necessary.

A sacrifice of the relational component

NICE mental health treatment guidelines are tied to a ‘gold standard’ RCT methodology that is influenced by a positivist philosophical paradigm (Williams, 2015). Therefore, the therapeutic alliance and claims that it is a key factor in therapeutic outcome are hindered by its inability to be ‘experimentally manipulated’ (DeRubeis, Brotman & Gibbons, 2005; Wampold, 2005). The positivist view of ‘psychology’ suggests that theoretical statements are only valid if empirically tested and verified, which poses issues when looking at concepts such as intersubjectivity and the therapeutic alliance (Orlans & van Scoyoc, 2009). The notion of intersubjectivity postulates that we are fundamentally and inextricably intertwined with others (Crossley, 1996) and, alongside the therapeutic alliance, is based on a more constructivist philosophy that is embedded in all relational forms of clinical theory and practice (Rizq, 2010b).

The IAPT ‘low intensity’ (i.e. guided self-help, psychoeducation) manual (Richards & Whyte, 2011) and ‘high intensity’ (i.e. psychotherapy) curriculum (Department of Health, 2008a, 2008b) do briefly reference the ‘therapeutic alliance’ and ‘therapeutic relationship’, respectively. Yet, the prevailing positivist research paradigms that influence IAPT and its evidence-based treatments seem to undermine these relational forms of clinical theory and practice. Studies by Addis, Wade, and Hatgis (1999) and Addis and Krasnow (2000) examined therapists’ attitudes towards evidence-based treatment and found that, whilst therapists were supportive of its view of science, they

were concerned about the impact of standardised manuals on the therapeutic alliance and individualised case conceptualisation. Another study (Nelson & Steele, 2007) about therapists' attitudes towards manualised treatment similarly showed that therapists were concerned about evidence-based treatments, not as a consequence of negative attitudes toward research but, instead, based on their sense of the reduced opportunity to exercise their own clinical judgment, and on fears that research-based protocols do not fully address the complexity of their cases. It appears that the positivist research and outcome agenda characteristic of evidence-based treatments has come to be at odds with the relational approach to therapeutic practice.

Within the positivist approach to mental health treatment the therapist's 'use of self' offers a variability in outcomes (Crits-Christoph, Baranackie, Kurcias et al., 1991; Crits-Christoph & Mintz, 1991; Huppert, Bufka, Barlow et al., 2001; Kim, Wampold & Bolt, 2006; Wampold & Brown, 2005), which seems to diminish the significance of the therapist in the psychotherapeutic endeavour. It has been argued that positivist assumptions can serve to hinder the progression of CBT research (Lyddon, 1995) and has been suggested that the integration of constructivist research paradigms can offer a plurality of perspectives to further our knowledge of CBT and the reduction of psychological distress (Grant, 2009). However, within the current climate, massive and increasing economic pressures impacting on public sector services (Royal College of Psychiatrists, NHS Confederation Mental Health Network & London School of Economics and Political Science, 2009) seem to put a strain on our efforts to achieve paradigmatic balance and strengthens the appeal of manualised, ready-made, cost-effective mental health treatments.

Therapy ‘efficacy studies’ and ‘outcome research’ trials have prompted a precise description of psychological treatment from one another, sponsoring a rapid growth in treatment manuals (Luborsky & DeRubeis, 1984). Supporters of manualised therapies believe that these forms of scientific scrutiny lead to quality evidence (Clark, Layard, Smithies et al., 2009). This becomes particularly relevant within the NHS IAPT services, firmly embedded within a medical, positivist, and objective view of science to provide the most evidence-based and cost-effective mental health treatments (Ham, 2009; McGrath & Lowson, 1986).

Today, CBT has become the poster child for the NHS IAPT services because it is the only evidence-based manualised intervention recommended for both depressive mood and anxiety disorder (Clark, 2011). Recognising the overwhelming economic pressures and diminished funding that deeply impacts the NHS, it has been argued that its ‘Payment by Results’, which pays services for each successfully treated case (O’Reilly & Kingsnorth, 2004), creates a ‘market for care’ where protocols, targets, and outcomes have the potential to subvert the client’s psychological needs (Rizq, 2012). In this way, the prevailing political culture seems to be seduced by the idea of CBT as a ready-made solution at the expense of its more relational forms of clinical theory and practice.

CBT as a model

It is important to make a distinction between the protocol-based CBT that currently predominates in IAPT services and CBT as a model per se, which is more relational and individualised, and reflective of what CBT is and can be. CBT can be a collaborative process that facilitates increased self-awareness and self-compassion,

and serves as a good motivator to the therapeutic process (Westbrook, 2014). It combines a client's presenting issues and experiences with theory and research to synthesise a new individualised understanding (Kuyken, Padesky & Dudley, 2009). This starts at the formulation, a key element of CBT (Beck, 2011), by which the therapist and client together identify the client's presenting issues in a theoretically informed, salient, and meaningful way to guide effective interventions (Dudley & Kuyken, 2014). The CBT approach can focus on examining, testing, and challenging the contents of clients' cognitions (Beck, 2011), as well as, on exploring clients' relationships and processing styles to facilitate a process by which distressing thoughts can be understood and accepted (Hayes, 2004; Westbrook, 2014). This collaborative process signifies the strong relational component of CBT practice (Orlinsky, Geller & Norcross, 2005), which, alongside other psychotherapy models, demands a high degree of self-awareness from therapists. In fact, the CBT therapist's capacity for self-reflection is considered one of the key elements that distinguish the learning of sophisticated interpersonal skills from the learning of technical or conceptual skills (Bennett-Levy & Thwaites, 2007).

An Evidence-Based Approach to Personal Therapy

CBT training does not formally encourage the use of personal therapy. Yet, a developing evidence-base for incorporating reflection in CBT training has emerged: the self-practice/self-reflection (SP/SR) approach, formalised in a training context as a self-experiential and reflective tool to enhance clinical practice (Bennett-Levy, Thwaites, Chaddock & Davis, 2009; Bennett-Levy, Lee, Travers et al., 2003; Bennett-Levy, Turner, Beaty, Smith, Paterson & Farmer, 2001; Laireiter & Willutzki, 2005). SP/SR serves to facilitate a more advanced reflective 'system', enabling a

progressively refined set of therapeutic skills, which can be particularly helpful when interpersonal ruptures arise that threaten the therapeutic relationship (Bennett-Levy, 2006). Bennett-Levy, Thwaites et al. (2009) argue that, in comparison to SP/SR, personal therapy is less targeted as a training tool and is typically a longer and deeper process that focuses on the self without necessarily having clinical implications.

SP/SR is a structured training experience in which trainees practice CBT techniques on themselves (SP) and then complete written reflections (SR) that focus on their experiences, implications for their clinical practice, as well as, implications for cognitive theory (Bennett-Levy et al., 2003). Two forms of SP/SR have been developed: one in which trainees practice on their own, and another in which they take turns offering and receiving ‘co-therapy’ with another trainee for about four to six weeks each (Bennett-Levy & Thwaites, 2007). Participants of SP/SR report a wide range of benefits, primarily to their interpersonal skills (Bennett-Levy, 2005). For example, one participant wrote, “...having experienced [co-]therapy has deepened my understanding of the importance of a good therapeutic alliance, collaboration, interest, trust, acceptance, compassion, etc.” (Bennett-Levy & Thwaites, 2007, p. 275).

The suggestion of SP/SR in the UK as a superior CBT training tool to personal therapy (Bennett-Levy, Thwaites et al., 2009) highlights a particular consideration of what might be useful for professional development during and post-training. During training, self-practice of CBT techniques might be important for developing a solid and cohesive identity as a CBT therapist (Laireiter & Willutzki, 2005), whilst later in professional life the experience of alternative therapeutic techniques, such as personal

therapy, might serve to enrich and broaden one's professional competence (Willutzki & Botermans, 1997).

Reframing the relationship in positivist terms: The self-reflective tool

In accordance with the prevailing positivist culture, empirical evidence indicates that 'the collaborative therapeutic relationship' is central to CBT clinical practice and significant to the outcome of therapy (Bennett-Levy, McManus, Westling & Fennell, 2009). Although the value of self-experiential and reflective strategies within the CBT model continue to seek empirical verification to appease positivist paradigms (i.e. to use behavioural skill measures rather than self-report measures), CBT therapists are increasingly starting to recognise that their interpersonal behaviour with clients can have a significant impact on the course and outcome of treatment (Geller, Norcross & Orlinsky, 2005). Furthermore, a growing empirical base and an increasingly coherent theory of personal and professional development encourage CBT therapists to participate in SP/SR as frontline training strategies (Laireiter & Willutzki, 2005).

The SP/SR training tool enhances self-awareness and serves to integrate the CBT model's technical and relational components: to involve both the 'self-as-therapist' and the 'person of the therapist' (Bennett-Levy and Thwaites, 2007). In line with its integration of relational and technical components, the CBT framework conceptualises self-awareness as a practical, metacognitive skill that enables the therapist (a) to reflect-on-action (after the session) and reflect-in-action (during the session) (Bennett-Levy et al., 2003; Schön, 1983); (b) to develop perceptual skills (Greenberg & Goldman, 1988; Rice & Greenberg, 1984); and (c) to develop a more mindful practice (Epstein, 1999; Safran & Muran, 2000).

However, the extent of the CBT model's dedication to positivist research and practice within IAPT threatens its position as a model, to simply becoming an evidence-based psychological therapy (Gilbert & Leahy, 2007). Within IAPT, therapist training follows nationally agreed curricula that focus on the competencies required to deliver mental health treatments that have been shown by RCTs to be effective for specific conditions (Fonagy & Clark, 2015). This increasingly strict adherence to evidence-based CBT techniques runs the risk of diminishing its clinicians to psychological mechanics (Leahy, 2005). Given the significance of the therapeutic relationship and therapists' self-awareness to CBT clinical outcome (Gilbert & Leahy, 2007), I argue that more emphasis should be placed on integrating notions of reflexivity and intersubjectivity into the current, dominant, rather objective CBT perspective on human connection: to bring the relational to the forefront, alongside its evidence-based techniques.

Personal Therapy and Clinical Practice: Positivist vs Phenomenological Perspectives

Curiously, much of the research on the topic of personal therapy has adopted a quantitative paradigm, incorporating surveys and other 'objective' self-reporting questionnaires to assess a rather subjective impact of personal therapy on clinical practice (i.e. Darongkamas, Burton & Cushway, 1994; Daw & Joseph, 2007; Lorentzen, Rønnestad & Orlinsky, 2011; Norcross, 2005; Orlinsky et al., 2011; Pope & Tabachnick, 1994; Sandell, Carlson, Schubert et al., 2006; Schroeder, Pomerantz, Brown et al., 2014). For example, a large-scale international study conducted by the Collaborative Research Network of the Society for Psychotherapy Research (Orlinsky

et al., 1999) collected data on the personal therapy experiences of over 3,500 therapists of diverse professions and various theoretical orientations in the United States, Germany, Switzerland, Norway, Denmark, Sweden, Portugal, Spain, Belgium, South Korea, New Zealand, Israel and Russia. Despite variations in specific percentages, the results were generally consistent across countries with positive benefits reported by 80 to 90 percent of therapists. The focus of this research was on the value personal therapy had for the therapist as a person and suggested that therapists found that their experiences of personal therapy could be translated into their clinical practice.

In 2001, Orlinsky, Botermans, and Rønnestad conducted a slightly larger international study of 4,000 therapists, which found that personal therapy ranked amongst the top three sources of positive influence on professional development, just behind direct clinical experience and formal case supervision. And the more senior therapists with 25 to 50 years of experience ranked personal therapy as the second most positive influence on professional development. Overall, more than 75 percent of the participants reported significant positive influences of personal therapy on professional development, and fewer than two percent identified personal therapy as negatively influencing their professional development. Orlinsky, Rønnestad, Wiseman, and Botermans (2002) next conducted a study with over 500 American therapists that they then replicated amongst 300 Norwegian therapists. In addition to questions about their personal therapy, this study asked therapists to rate the quality of their childhood experiences. Findings revealed that the quality of therapists' childhood experiences had a pervasive influence on their current adult experiences and that the apparent influence was notably lower amongst therapists who had what

they found to be a highly beneficial personal therapy. This study suggested that a successful experience in personal therapy can significantly attenuate the impact of remembered childhood experience on critical areas of adult functioning. It further proposed that successful personal therapy helps therapists make peace with the past, and to experience adult life and work relatively unburdened by the impact of childhood events (Orlinsky, Norcross, Rønnestad & Wiseman, 2005).

Subsequently, Orlinsky, Norcross, Rønnestad, and Wiseman (2005) reviewed empirical evidence of the outcome and impact of personal therapy amongst psychotherapists (Buckley, Karasu & Charles, 1981; Liaboe, Guy, Wong & Deahnert, 1989; Norcross, Dryden & DeMichele, 1992; Norcross, Strausser-Kirtland & Missar, 1988; Patterson & Utesch, 1991; Pope & Tabachnick, 1994) and confirmed that, across the board, at least 90 percent of participants found personal therapy to be effective and reported improvement in self-esteem, work functioning, social life, character conflicts and symptom severity. These results offer us a list of facts, like ready-made solutions, that tell us that there are benefits to undergoing personal therapy, however, without telling us *how* personal therapy impacts clinical practice. Is the purpose of personal therapy simply to produce the kinds of personal benefits outlined above or is it to enhance the effectiveness of the therapist's clinical practice? These are potentially interrelated but distinct objectives and outcomes.

The empirical research literature is interested in attempting to determine whether therapists who have undergone personal therapy are more effective than those who have not (see Clark, 1986; Garfield & Bergin, 1971; Greenberg & Staller, 1981; Holt & Luborsky, 1958). Despite the many positive results, the research offers only

equivocal results about the suggested relationship between personal therapy and effective clinical practice (Macran & Shapiro, 1998; Macran, Stiles & Smith, 1999; Rizq & Target, 2008b). It remains difficult, and perhaps unfeasible, to demonstrate whether personal therapy results in a therapist's better clinical outcomes. Therefore, rather than continue to try to prove this elusive link, perhaps it is more appropriate to ask therapists themselves about *how* they use personal therapy in their clinical practice.

Macran, Stiles, and Smith (1999) revolutionised this research process by adopting a qualitative paradigm to capture the richness of this topic that failed to be captured through quantitative measures. This significantly smaller study interviewed seven practicing therapists who spoke about the unique contributions of their personal therapy in which their experiences as clients were translated into skills and attitudes utilised in clinical practice. This study suggested that the experience of helpful conditions in the participants' own therapy enabled them to provide similar conditions in their clinical practice. The shift in paradigm initiated a significant shift in focus to develop a richer theoretical framework of the relationship between personal therapy and effective therapeutic practice.

Rizq and Target (2008a, 2008b) subsequently conducted qualitative studies that drew on attachment-related research to contextualise results from an interpretative phenomenological analysis (IPA) of nine experienced counselling psychologists' descriptions of the meaning and significance of personal therapy. Analysis of participants' accounts suggested that participants found personal therapy to be valuable, primarily as a means of developing their ability to reflect on the self and to

use this self-awareness in clinical practice. The (2008b) study further considered that personal therapy could be a valuable vehicle for a genuine and often intense relationship to facilitate authentic emotional contact with oneself and one's clients. This study further identified findings comparable to that of Macran, Stiles, and Smith (1999), such as the acknowledgement of the intensity of experiences within personal therapy, and that personal therapy supports one's capacity to be and use one's 'real' self.

Rizq and Target (2010) later conducted a mixed methods study to more specifically explore how counselling psychologists' attachment status and levels of reflective functioning intersect with how they experience, recall and describe using personal therapy in clinical practice. The analysis suggested that participants who identified as securely-attached used therapy to manage complex feelings evoked by difficult or challenging clients, whilst participants who identified as insecurely-attached found therapy valuable regarding behavioural modelling, but not in managing complex process issues. More generally, appreciation of another's mental state appeared to be embedded in participants' early attachment relationships. This led to a reflexive observation of the significance of the researcher's subjectivity and relational style and how it can impact the research process and outcome and highlights the considerable feat of the qualitative researcher's challenging endeavour to capture the richness of another's experience.

Conclusions and the Research Question

Despite the many positive effects of personal therapy on clinical practice, the literature has revealed difficulties that researching this field entails. Mainly, it remains

difficult and seemingly impracticable to evaluate whether personal therapy leads to better clinical outcomes (Greenberg & Staller, 1981; Clark, 1986; Macaskill, 1988; Macran & Shapiro, 1998). Ultimately, personal therapy cannot be systematically applied in a way statistically proven to enhance clinical outcomes. Although most therapists rate the impact of personal therapy on their practice highly (Bellows, 2007; Malikiosi-Loizos, 2013; Mearns, Thorne & McLeod, 2013; Orlinsky, Botermans, Rønnestad et al., 2001), objective evidence of its effectiveness remains weak (Bennett-Levy et al., 2003; Orlinsky, Rønnestad, Willutzki et al., 2005). The CBT model refers to the reflective ‘system’ as the ‘engine’ that drives lifelong learning as therapists (Bennett-Levy, Thwaites, Chaddock et al., 2009b; Schön, 1983; Skovholt & Rønnestad, 1992), yet it does not formally encourage the practice of personal therapy, seemingly due to its weak empirical link to clinical outcome.

Given the difficulty of establishing a linear relationship between personal therapy and clinical outcomes, there has been increasing interest in how therapists themselves understand the impact of personal therapy on their clinical work (Macran & Shapiro, 1998). Rizq (2011) confirms that “in the last decade there has been a shift in interest from whether to how personal therapy influences client work” (p. 177), reflected in recent research studies (see McMahon, 2012; Murphy, 2005; Rizq & Target, 2008a, 2008b). The revision from quantitative to qualitative methodologies, from objective outcome measures to subjective understanding of individual experiences, is more in line with the subjective and individualised nature of self-awareness and the collaborative therapeutic relationship, central to CBT clinical practice. Therefore, the purpose of this research study is to use qualitative methods to explore the perspectives of CBT therapists, a popular, yet under-researched, group within the field.

The prevailing positivist research agenda appears to be at odds with the constructivist and phenomenological epistemologies embedded in relational forms of clinical theory and practice (Rizq, 2010b). The practice of counselling psychology appears to straddle this seeming contradiction by drawing upon and seeking to develop phenomenological models of practice and enquiry in addition to that of positivist scientific research (BPS, 2015a). My position as a counselling psychologist is to marry these two models of practice and research: to embody both the ‘scientific-practitioner’ and the ‘relational-practitioner’ by participating in rigorous empirical enquiry upon a foundation of interpersonal awareness, contextual understanding and empathic identification (Rizq, 2010b). My interest in this research project developed from my search for a middle ground: to forge a compromise between the two extremes. Therefore, my research aims to acknowledge a plurality of perspectives that manifest within the evidence-based practices of the CBT model, by integrating a phenomenological philosophy of ‘truths’ into its more prevalent positivist approach to obtaining objective solutions. Given that the research on CBT therapists’ experiences of personal therapy is limited, and my personal interest in this topic, the following research question was developed: How do CBT therapists experience personal therapy in clinical practice?

METHODOLOGY

The divide between evidence-based therapy manuals and human connection can be considered a symptom of a dichotomy within the field of psychology, between quantitative and qualitative research. On the topic of personal therapy, a positivist view of psychology and its focus on objective empirical research poses difficulties. The conceptual limitations of the quantitative measures reviewed in the previous chapter are due to its traditional empirical methods, which can offer only equivocal results about the suggested relationship between personal therapy and effective clinical practice (Macran & Shapiro, 1998; Macran, Stiles & Smith, 1999; Rizq & Target, 2008b).

Ultimately, the quantitative paradigm does not permit the exploration of subjective meanings and lived experiences. In light of the richness of the experience of personal therapy, it may be more befitting to explore this area by accessing in-depth descriptions of participants' experiences: to ask CBT therapists themselves about how they use personal therapy in their clinical practice. My research design involves claims about the nature of reality (ontology), how I know it (epistemology) and my process for studying it (methodology); key considerations of the research project (Crotty, 1998) that will now be explored.

Qualitative Research

Qualitative methods tap into the subjective inner world of a person and have been built upon existential philosophies, such as Heidegger's attempt to refocus Western assumptions about objective truths back to fundamental questions of 'being' (Orlans

& van Scoyoc, 2009). My position as a Counselling Psychologist is similarly underpinned by humanistic values and principles and assumes a 'scientist-practitioner' model that is phenomenologically-focused and interested in exploring subjective truths (Woolfe & Dryden, 1996). Therefore, a qualitative approach, based on a humanistic and phenomenological foundation of counselling psychology, has been deemed most appropriate for exploring CBT therapists' experiences of using personal therapy in their clinical practice.

Constructivism/Interpretivism

The constructivist/interpretivist paradigm can be seen as an alternative to the positivist paradigm (Ponterotto, 2005). Its relativist ontology supports the existence of multiple realities rather than one single reality. The notion of reality is then subjective and influenced by the context of experience, perceptions and the interactions between self and other (Drummond, 2007). There are multiple meanings of a phenomenon in the minds of the people who experience it, along with multiple interpretations of the people with whom the experience is shared (Ponterotto, 2005). This phenomenological and subjectivist stance maintains that one's reality is constructed between self and other, a dynamic interaction that translates between researcher and participant and is central to understanding and describing one's lived experience.

Epistemology

The epistemological foundation of phenomenology that I have adopted is based on the ontology that, as we are a fundamental part of a meaningful world, which is also a fundamental part of us, we can only be understood as a function of our various involvements with this meaningful world (Larkin, Watts & Clifton, 2006). This

phenomenological approach requires the gathering of rigorously descriptive research that explores the intentional relationship between person and situation, to reveal the inherent essence of meaning within human experience (Giorgi, 1989). Therefore, I have gathered rich descriptions of lived experiences of which I adopted an open attitude to (at least initially) refrain from important external frameworks and judgments (Finlay, 2009).

Humans are embedded in this world along with the thoughts and meaning systems that result from being in the world and, therefore, it is impossible to remove myself in a way to determine a definitive truth of how things ‘really’ are (Larkin et al., 2006). Whilst reality might not depend on humans, the meaning and nature of reality do (Dreyfus, 1995), and this knowledge is built through language and how people make sense of and understand their worlds (Denzin & Lincoln, 2011). Phenomenology gives precedence to the inherent process of reflexivity when making meaning of one’s own experiences. Brunner (2004) suggests that the story of one’s own life is reflexive in that the narrator and main character in the narrative are the same person, defining reflexivity as one’s *turning on oneself*. This, too, emerges from interpretation, an inherently relational activity, that embraces both the desire to understand and the impulse to connect (Tappan, 1997a).

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was developed by Jonathan A. Smith to allow researchers to produce theoretical frameworks based on and transcending participants’ personal terminologies and conceptualisations (Smith, 2004). It is phenomenological in its concern for individual perception and depends on an

idiographic and inductive method to explore personal lived experience (Finlay, 2009). IPA is idiographic in its commitment to analyse individual cases in a corpus in detail, embracing the significance of particular utterances, the depth of interpretations, and the sensitivity of analysis (Smith, 2011a, 2011b). It focuses on individual accounts of specific situations and typically involves the highly intensive and detailed analysis of a comparatively small number of participants (Larkin et al., 2006). The detailed analysis of each case is then followed by a search for patterns across the cases (Smith, 2011a).

IPA is based on the epistemological stance that through subjective meaning-making it becomes possible to access individual cognitive inner worlds, which is especially suited to psychological theory (Smith, 1996). Smith (2011c) defines IPA as “phenomenological in its concern with lived experience and...interpretative in recognising the analysis of experience as a hermeneutic activity” (p. 6). Its theoretical underpinnings stem from Husserl’s philosophy of consciousness and hermeneutic theory of interpretation and symbolic interactionism, which suggest that personal meaning ascribed to an experience can only be accessed through an interpretative process (Marriott & Thompson, 2008). Chamberlain (2011) appropriately declares that this method of research pursues “what the data *means*, not what it *is*” (p. 52).

Phenomenology

Phenomenology is the philosophical movement concerned with the meaning of an experience, how one makes sense of that experience, and involves a detailed examination of personal lived experience in its own terms (Smith, 2011a). If the focus is not on a lived experience and the description of how things appear, it is not

phenomenological (Finlay, 2009). A phenomenon of existential importance will be expressed in a “full, textured, emotionally powerful, consequential narrative form” (Charon, 2006, p. 13). Humans order their lives through narratives, interwoven with hopes, desires, memories, fantasies, intentions, representations of others, and time experiences as life history (Josselson, 2004). Histories are subjectively recounted in linguistic form as stories expressing the connectedness of human experience; making the implicit explicit (Ricoeur, 1991).

Edmund Husserl (1859-1938) was a philosopher who first shed light on an epistemological problem concerning the relationship between the subjectivity of knowing and the objectivity of what is known (Husserl, 1983). From this he went on to develop the philosophical foundations of phenomenological enquiry, to examine experience in the way that it occurs, in its own terms (Smith, Flowers & Larkin, 2009). He believed that certain or objective knowledge could only be attained via processes of consciousness (Larkin et al., 2006).

Husserl served as a mentor to Martin Heidegger (1889-1976) who extended the concept of phenomenology, beyond a reference to some *thing* appearing in its own terms (Smith, 2011c), to suggest that thought—and the essence in which humans engage with the world, is *ad hoc* in nature and also intentionally directed (Dreyfus, 1995). Unlike Husserl, Heidegger believed that the intentionality of human activity is part of an *unconscious* mental process. His position further suggested that all things become some *thing* when, and only when, one encounters it and when it is brought meaningfully into the context of human life (Polt, 1999). This existential shift was supported and developed by Hans-Georg Gadamer (1900-2002) and Paul Ricoeur

(1913-2005) who gave great precedence to the process of linguistic communication. Gadamer considered 'world-understanding' to be embedded in linguistic communication, and Ricœur signified narrative as its greatest form (Brockmeier & Meretoja, 2014).

Through the great philosophical works of Husserl, Heidegger, Gadamer, and Ricœur we can begin to understand the phenomenological emphasis on the experiential accounts of IPA research participants (Larkin et al., 2006). A phenomenological researcher reflects on the correlation of their subjective-relatedness of objects as experienced, to study transcendental consciousness as that which makes possible a significant world, with the aim of bringing such significance to awareness (Drummond, 2007). As an IPA researcher, I consistently reflected upon my experiences as a trainee, therapist, researcher and client to explore how they intertwine, to make meaning of my experiences, and to bring its significance to my awareness. The challenge is signified in the analysis of participants' experiences, carried out by an 'other' (me as the researcher) and, therefore, is of the other's (my) experience (Smith, 2011a). To accommodate this challenge, I participated in a process of engagement and interpretation, of connection and separation, to tie in a hermeneutic perspective (Smith, 2011a).

Heidegger united phenomenology and hermeneutics to facilitate the explicit study of meaning-making and how things appear and are covered up at the same time (Moran, 2000); linked together by interpretation. How things appear or are covered up are explicitly studied, each *thing* presenting itself in a manner that is concurrently self-concealing (Moran, 2000). Hermeneutics offers up-close and personal access to

phenomenology (Smith, 2011c) and will be explored in greater detail later in this chapter.

Interpretative phenomenology

IPA involves two components: phenomenology and interpretation. The phenomenological component maps out the participants' concerns and cares in the form of experiences claimed for themselves, and precedes the interpretative component that contextualises these claims and attempts to make sense of the constitutive relationship between the person and world, within a psychological framework (Larkin et al., 2006). In other words, phenomenology seeks meaning, meaning is difficult to grasp, and so interpretation is necessary (Josselson, 2004). Heidegger identified a significant distinction between the notion of phenomenology, which implies the exploration of something as itself, and the notion of interpretation, which, in contrast, demands that something is deliberately explored as something else (Dreyfus, 1995).

My method of phenomenological description embodies an interpretative process, an inevitable and basic structure of one's *being-in-the-world* (Heidegger, 1962).

Interpretative phenomenology emerged from hermeneutic philosophy, including works from Heidegger, Gadamer, and Ricœur, who shared the conviction of one's embeddedness in the world of language, one's special relationships and one's historicity of understanding (Finlay, 2009). Heidegger's hermeneutic tradition emphasises humans' ongoing need for understanding, self-resolution and the use of narrative through which one interprets their being in the world (Brockmeier & Meretoja, 2014). Gadamer (1975/2013) suggests an openness and neutrality required

of phenomenologists, situating an *other's* meaning in relation to one's own meaning, that depends on appropriating—at the foreground, one's own prejudices and fore-meanings. He states, “The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings” (p. 269). I have been challenged by the simultaneous embodiment of contradictory attitudes: being scientifically *removed* from, open to and aware of, whilst also *interacting* with the participants amidst their own experiencing (Finlay, 2008). Thus, phenomenological understanding that is also interpretatively analysed requires a hermeneutic enterprise.

Hermeneutics

In IPA research the participant gives the narrative, through which he or she constructs a reflexive interpretation of his or her experience, which the researcher then reflexively reconstructs to offer a different level of discourse (Josselson, 2004). This describes a ‘hermeneutic circle’, a dynamic interpretative process that requires discrimination, a constant moving and mutual illumination between part and whole (Smith, 2011c). Through this circle of belief and understanding, meanings derive from a consideration of the whole, which itself is created through an understanding of the parts (Ricœur, 1970). Smith (2007) more simply states, “To understand the part, you look to the whole; to understand the whole, you look to the part” (p. 5).

The hermeneutic tradition recognises the central role of the researcher and assumes that interpretation essentially involves a circularity of understanding, identifying the ‘knower’ (participant) and the ‘known’ (data), the part and the whole, as fundamentally interrelated (Smith, 2007; Tappan, 1997a). I was offered entry into the

hermeneutic circle through participants' interpretations of life events, which offered further insight into their life-worlds; expressed with unconscious conflicts and desires, and identified cultural resources, moral rules, and unique social interactions (Larkin et al., 2006). Whilst my perspective had initially (and perhaps inevitably) shaped my interpretations, I tried to remain open to revision and elaboration through which my perspective and understanding—along with my biases and blind spots, were continuously acknowledged and evaluated (Tappan, 1997a).

My first aim was to try to understand and then describe the meaning behind participants' experiences. However, access to this information was partial and complex (Larkin et al., 2006; Smith, 1996). My second aim was to develop an overt interpretative analysis to provide a critical and conceptual commentary of participants' personal sense-making activities (Smith & Osborn, 2015). More specifically, I examined *what it meant* for the participants to have made such claims and to have expressed such feelings and concerns regarding their use of personal therapy in CBT clinical practice (Larkin et al., 2006). However, all discoveries that were made were considered a necessary function of the relationship between myself as researcher and participants; between person and world, subject and object, which presented a dilemma of reflexivity (Larkin et al., 2006). I worked hard to enhance my self-awareness of pre-existing beliefs and to develop a critical self-awareness of my own subjectivity, to examine and question myself in light of new evidence and to be conscious of how I might impact the research (Finlay, 2008, 2009; Halling, 2008).

My interest in the field of counselling psychology developed during and *within* my personal therapy. My experiences as a highly emotional child in a highly intellectual

family posed a seeming contradiction between feeling and thinking from a very early age. My endeavour throughout training has been to narrow this contradiction within myself, which I have come to realise is not much of a contradiction but, rather, a divide. I have experienced a similar divide within the psychotherapy professions: between positivist and constructivist claims for truth; between the manualised use of protocols and the use of the relationship between client and therapist; between evidence and reflection. My attempts to narrow this divide manifests in my curiosity about how CBT therapists describe the significance of their personal therapy in clinical practice.

Throughout the research process, I have acknowledged my resistance to the steady political pull towards a positivist, medicalised approach to mental health care, which I find undermines the relational components of clinical theory and practice. I also find personal therapy to be essential to working with the relational demands of my clinical practice. My pre-existing beliefs and assumptions about the medical model and the positive benefits and values of personal therapy had to be monitored closely to adapt my language and attitude into a more neutral stance: to locate, acknowledge and bracket myself-in-context so that I could be more sensitive and alert to each unique participant-in-context.

Heidegger identified a 'person-in-context' as the very nature of humans, being in the world, located and observable in our relatedness to some meaningful context (Larkin et al., 2006). Therefore, I am a 'person-in-context' seeking to make meaning of another 'person-in-context', which highlights the inescapable nature of my own preconceptions (Larkin et al., 2006; Smith, 2007). Developing a Heideggerian

phenomenology has depended on my empathic attunement to the subject matter and preparedness to bring awareness as well as adjust ideas and assumptions in response to the promptings of the subject matter (Larkin et al., 2006). I have endeavoured to examine the phenomena as it appeared, facilitated by the analysis, to help grasp what was being shown (Smith, 2007).

The hermeneutics of faith and suspicion

Ricœur (1970) proposed two distinct hermeneutic stances: one which aims to ‘restore’, or have faith in, the meaning offered by people; and another which aims to ‘demystify’, or be suspicious of, the meaning offered by people, as if in the form of disguise. My position lies on the thin line between the hermeneutics of faith and suspicion, conceiving the interpretative process to distil, elucidate and illuminate the intended meanings of participants, whilst also discovering meanings that lie hidden within the unconscious (Josselson, 2004).

The hermeneutics of faith is what ‘re-presents’ and gives voice to the meanings accepted as relatively transparent—with an interpretative edge, to develop the self-understanding of participants (Josselson, 2004). Its epistemological basis derives from the Husserlian phenomenology of experience through which participants are considered to use narrative accounts as a process of self-formation, through experiences of learning or conflict, through further which the researcher seeks to unearth inherent meaning; remaining faithful to the narrator’s intentions (Tappan, 1997b). This hermeneutic stance is one of recollecting and reordering meaning inherent in personal accounts (Gwyn, 2000). Kvale (1996) highlights the dilemma of grasping a good understanding of participants and suggests that, to achieve ‘a purer distillation of meaning’ (Josselson, 2004), we must acknowledge that the context of

the interviews and the nature of the research relationship can affect the meanings thus produced. In my experience, the genuine personal encounters between myself and participants facilitated the disclosures of inner, authentic, and important meanings (Josselson, 2004). Furthermore, this environment facilitated a shared experience through which new levels of understanding and meaning-making could evolve.

This is where the hermeneutics of suspicion has entered my interpretive process, in which a more sceptical perspective helped reveal underlying processes. The hermeneutics of suspicion is interested in what is hidden and latent (Josselson, 2004). I sought to explore the self-understanding and meaning making that operated outside of participants' immediate awareness—at first *with* each participant, to facilitate a process of enhanced self-awareness. I wanted to understand the participant's subjective meanings before being able to consider what meanings lay hidden and fluctuated between the positions of accepting the participants as the authors of, and having authority over, their own experiences (Josselson, 2004).

All hermeneutics share an interpretive effort to uncover the world of the people under study. However, there are distinct processes in which the researcher can get there (Josselson, 2004). My epistemological stance assumes that participants have described to their greatest capacities how they have perceived their experiences; and that my role is to 're-present' to myself and the readers of this study what the participants were conveying to me to the best of my capacity (Josselson, 2004). This process embraces the equivocal nature of language (Ricœur, 1970), which communicates an untold story alongside the told story, and I have intended to reveal both aspects. Ricœur (1970) supports the researcher's oscillation between

demystifying and restoring meaning, with a shared focus on what is said and what is not said: to identify what meanings are intended and which are unintended.

Ricœur's (1970) intersubjective definition of truth, as a natural movement towards self-clarification by unfolding perceptions of the world and communications with others, appears to describe the essence of narrative research from both hermeneutic stances: of faith and suspicion (Josselson, 2004). Smith (2001c) agrees that, "The phenomenon lies, in part, latent, underneath but connected to the manifest, and it can come into visibility," as "something hidden comes to light during the process of hermeneutic phenomenology" (p. 12). Alongside participants' awareness of their own meaning-making, I hoped to facilitate the illumination of a smaller, quieter new meaning embedded within the louder and larger corpus (Smith, 2011c). Smith (2011c) coined the term 'gems' to describe such illuminations, which require a fluctuation between 'appearing' and 'peering', and which involves three elements: the phenomenon that consciously appears, the peering role of the researcher, and the awareness and recognition of the participant.

You will find that each participant's phenomenological account has been centralised, contextualised and analysed in detail to learn about their cognitive and affective reactions to specific phenomena (Larkin et al., 2006). This narrative act has offered participants a way to convey what they have gone through and, in exchange, has offered me a way to consider and grasp what their experiences have meant to them (Brockmeier & Meretoja, 2014). I have then described what emerged from the narratives just as they are (Drummond, 2007), which is meant to demonstrate my capacity to be aware of my own standpoint whilst open to an *other's*: to appropriately

filter what belongs to me, what belongs to each participant, and what is shared between us (Josselson, 2004). My role as an IPA researcher has been to extend the scope of the reservation of judgment to include all experience, my own as well as that of each participant, to focus my attention on possible experiences that present as themes relevant across participants (Drummond, 2007).

IPA Method

IPA is a qualitative research method that facilitates access to personal meanings and sense-making amongst individuals who share an experience (Smith et al., 2009). This methodology is most relevant to my focus on accessing the subjective lived experiences of CBT therapists who have undergone personal therapy. IPA incorporates semi-structured interview schedules to allow participants greater scope to express the ways in which they make sense of their experiences, and was used for a direct exploration of how personal therapy is experienced in CBT clinical practice. Furthermore, IPA promotes a distinctly inductive and interrogative approach to theoretical development (Smith, 2015). Rather than test previously established hypotheses, I attempt to contribute to and critique existing psychological research and literature, to develop a distinct psychological perspective to the limited extant research literature in the field.

IPA is met with challenges of its own, mainly in regards to one's capacity to achieve an accurate understanding of another's subjective lived experience. Subjective lived experiences cannot be accessed directly but, rather, requires some interpretative activity on the part of the researcher, to focus on what is particular and distinct about each individual participant (Rizq & Target, 2008a). IPA is a form of

phenomenological enquiry that incorporates a reflexive, inter-subjective stance to engage with participants' language, stories and experiences (Smith et al., 2009). IPA then draws from the participant group as a whole to inductively and interrogatively support individual accounts and search for patterns across the cases, to develop themes (Smith, 2011a).

Criticisms of IPA

One of the main criticisms of IPA is its seeming lack of concern for the proper use of its method based on scientific criteria, and how the steps of the IPA method meet human scientific criteria (Giorgi, 2011). Many are not satisfied by the expectation that an IPA study should be apparent by the demonstration of a phenomenological and hermeneutic stance (Smith et al., 2009). For example, unlike sociological approaches (i.e. grounded theory), IPA does not build on each participant's account to extract a universal model from the data (Charmaz, 2015). Grounded theory was considered as an alternative qualitative approach for this research project. If chosen, it could have offered insight into the social processes underlying participants' experiences of personal therapy in clinical practice, as well as, an overall theory of how participants use personal therapy in clinical practice and of how it relates to social and contextual factors. However, I was not interested in assuming there was a theory of a process of how personal therapy influences clinical practice.

Discourse and Conversation Analysis were also considered and could have offered insight into the performative functions of participants' dialogue and how language is used in interaction to construct a particular view of oneself and the world (Larkin et al., 2006; Smith, 2011a; Willig, 2015). However, I was not interested in making

claims about the function of participants' use of talk. Instead, I was interested in developing a phenomenological understanding of what it is like for participants to have therapy and to use it in their CBT clinical practice. Heuristics was also considered as an alternative methodology and could have offered a more explicit acknowledgement of my personal involvement as the researcher of this research project by making my own lived experience of using personal therapy in clinical practice the main focus of the research (Moustakas, 2001). However, not having practiced CBT, I did not have lived experience of the research question. Overall, although other qualitative methodologies had been considered, for the purpose of this research project, IPA was selected as the most suitable approach due to its assumption that language has the ability to tell us about an individual's experience, what one feels and thinks, for the purpose of offering insight into how a person, in a given context, makes sense of a given phenomenon.

Issues of validity and reliability

Qualitative research has long been evaluated according to criteria of validity and reliability as applied to quantitative research. Smith et al. (2009) assert that, whilst validity and reliability are important considerations, qualitative research should be evaluated with more appropriate criteria. Yardley (2000, 2008) recommends following four principles to assess the quality of qualitative research:

- 1) Sensitivity to context – sensitivity towards participants, their accounts, and from the onset of the research process (i.e. choosing the research topic, recruitment, the interview schedule, etc.).
- 2) Commitment to rigour – the attention towards participants before, during and after interviews; taking care in how the analysis is carried

out; and the thoughtfulness of the study (i.e. in choosing the sample, developing the interview questions, etc.).

- 3) Transparency and coherence – clearly documenting the stages of the research process; the careful writing and re-writing of drafts; and the degree to which the research and the method complement each other.
- 4) Impact and importance – that the research reveals something important or useful.

These criteria were reviewed and referred to throughout the research study to enhance the quality of this research project. For example, to maintain ‘sensitivity to context’ I was mindful of my empathic communication from the first point of contact and throughout my contact with participants. My focus was on putting participants at ease and considering interpersonal difficulties as they arose. This was particularly relevant to my experience as a trainee and novice researcher interviewing experienced therapists. I remained curious as to how my experience interacted with participants’ experiences of being interviewed and the potential power plays that appeared between us. I found supervision particularly helpful in maintaining a balance between following participants’ leads and digging deeper. One example of my ‘commitment to rigour’ arose during the early stages of analysis, when I started to experience feelings of protection over participants. I was careful with my interpretations because I wanted to maintain the essence of each participant, and so I often asked myself: if the participant was to read this, could they recognise themselves? To uphold ‘transparency and coherence’, I offered participants the opportunity to read over their transcripts and, later, to review and provide feedback on their individual analyses before I completed cross analysis. I have valued and learned from participants’ experiences and, in support of this study’s ‘impact and importance’, I have respectively drawn from their accounts to raise awareness of their experiences and to arouse curiosity and interest in the psychotherapy professions, which will be

demonstrated in the Discussion section.

Recruitment

I collected data from an information-rich, rather than representative, participant pool (Rizq & Target, 2008b), meaning that access to a small group of participants, all who have lived experience of my topic of interest, was crucial to ensure this study would elicit sufficiently rich, in-depth data. Therefore, I recruited a homogeneous and purposive sample, a closely defined group of seven participants for whom the research question was significant (Smith, 2015). The following inclusion criteria were determined based on its relevancy to the research question (Willig, 2015), and were applied to establish homogeneity:

- 1) Each participant was to have Full Accreditation as a Cognitive Behavioural Psychotherapist by the British Association for Behavioural and Cognitive Psychotherapy (BABCP).
- 2) To further establish a homogeneous sample characterised by similar professionals with extensive clinical training experience, inclusion criteria extended beyond the Minimum Training Standards of the BABCP (expected of psychologists, psychotherapists, psychiatrists, nurses, counsellors and social workers alike) and requested qualifications of both a degree and a doctorate in psychology.
- 3) Within the CBT framework personal therapy is distinct from ‘self-practice’ and ‘self-reflection’ training goals (Bennett-Levy et al., 2001) and is defined as a longer and deeper process that is less targeted as a training tool (Bennett-Levy, Thwaites et al., 2009). In line with this definition, inclusion criteria required participants to have at least five years of post-accreditation clinical experience along with the experience of undertaking at least weekly personal therapy for a minimum of two years.

- 4) To increase potential efficacy and reduce the risk of indoctrination, inclusion criteria further requested that participants' experience of personal therapy be voluntary.

I recruited participants from the official public registers of the BPS and BABCP, through which names were cross-checked between both registers to identify potential participants. I made initial contact through email, which provided a brief description of the study and requested participation based on the inclusion criteria (see Appendix II). A Participant Information Sheet (see Appendix III) was also attached to the initial email to provide more detailed information about participation. I encouraged chain referral sampling (Patton, 1990), in which potential participants may have known and referred other potential participants, to facilitate the recruitment process. Involvement in the study was voluntary, and responses were both anonymised and remained confidential to the research team (Daw & Joseph, 2007).

My initial attempt at recruiting participants involved sending individual emails to 40 professionals who cross-checked on both BPS and BABCP registers. I received responses from two potential participants, one of whom agreed to participate. I realised the minimal response-ratio I could expect to receive and, therefore, sent blind-copy emails to 138 professionals with doctorates in psychology from both the BPS and BABCP public registers, which resulted in one more response from a professional who agreed to participate. Throughout the recruitment process, I contacted four University lecturers as well, wondering whether they might participate or know someone who might be interested. Discussion with one lecturer shed light on the limitations of my inclusion criteria, specifically in requiring participants to be both registered members of the BPS and BABCP; to be both chartered psychologists as

well as fully accredited CBT therapists. To maintain a homogeneous sample, I considered alternative ways to establish CBT expertise amongst similar professionals with extensive psychotherapeutic training experience. Adjustments of the inclusion criteria were discussed in supervision, and the following alternatives were applied:

- 1) To establish CBT expertise, participants were asked to have completed an accredited training in CBT.
- 2) To further establish a homogeneous sample characterised by similar professionals with extensive clinical training experience, participants were asked to have completed an accredited training in psychotherapy.

This resulted in a more successful recruitment process. I again sent blind-copy emails to the 138 professionals I had emailed before as well as to an additional 356 professionals on the BACP public register. I received responses from two more people who agreed to participate. I also received individual referrals to contact six potential participants of whom three agreed to participate. This resulted in a total of seven participants.

There were three men and four women with ages ranging from 35 to 71 (mean age 52). Professional qualifications included masters-level and doctorate-level degrees and diplomas in psychotherapy, as well as postgraduate diplomas and advanced certificates in CBT. Post-accreditation clinical experience ranged from nine to 22 years. Length of time spent in voluntary personal therapy ranged from four to 15 years (a mean of seven years). Some participants may have had therapy as part of their training, however, the additional voluntary therapy was the basis of their selection. Theoretical orientations of personal therapy varied. Each participant's demographic information is presented below:

Age	Gender	Professional title	Professional qualifications	Years of post-accreditation experience	Years of voluntary personal therapy	Theoretical orientation of personal therapy
71	M	Counselling Psychologist	BPS Chartered Psychologist, BABCP accreditation	22	5	Pluralistic, Humanistic
46	F	Health Psychologist	BPS Chartered Psychologist, BABCP accreditation	14	4	Psychoanalytic, Systemic
69	M	Psychotherapist	UKCP Registered Psychotherapist, BABCP accreditation	20	15	Jungian
42	M	Counsellor	BACP accreditation, Adv Cert in CBT	9	7	Integrative
48	F	Psychotherapist	BACP Registered, PG Dip CBT	10	7	Integrative
35	F	Counselling Psychologist	BPS Chartered Psychologist, Adv Cert CBT	10	6	Integrative
50	F	Counselling Psychologist	BPS Chartered Psychologist, BABCP accreditation	9	4	Psychodynamic, CBT

I, comparably, was a training counselling psychologist, with several years' experience of both clinical work and personal therapy. I found many benefits in the ways personal therapy had impacted my clinical practice, although had not used the CBT model in my clinical practice. Nonetheless, I owned my assumption that the benefits I experienced could be generalised.

Ethics

I followed the ethical regulations of Roehampton University, in line with the Health and Care Professions Council (HCPC) and British Psychological Society (BPS) guidelines. Prior to there being contact with participants, I obtained approval from the Ethics Committee at the University of Roehampton (see Appendix I).

Participants and I mutually agreed upon a time and place to meet. Interviews lasted for around one hour and took place either at the University of Roehampton or the participants' public offices or private homes. I read and adhered to the Lone Worker Policy at the University of Roehampton and, when interviews took place in a private place, I ensured that I was contactable by phone by a colleague who was aware of my specific location at all times.

Prior to the start of each interview, I read through the Participant Information Sheet (see Appendix III) with each participant. This process was meant to ensure that participants understood what the study was about and that they had the opportunity to ask questions or clarify anything concerning participation in this research study. Participants were then presented with the Consent Form (see Appendix IV) to be read, completed and signed twice so that both I and participants each retained an original copy. Participants were also asked to complete a Demographic Questionnaire (see Appendix V), which was used to enhance analysis.

Due to the high level of sensitivity necessary in dealing with the confidential and personal nature of this research topic, in-depth, semi-structured interviewing was considered the most effective method for data collection (Rizq & Target, 2008; Smith, 1995). Furthermore, given the personal nature of the interviews, it was important that I develop and maintain respect and trust with the participants (BPS, 2014; HCPC, 2012). Participants were informed about the aims of the research and were given the opportunity to ask any further questions at the end of the interview process.

There were ethical issues of anonymity and confidentiality that had to be considered. For example, participants could have consented to take part in the study and then subsequently request that their data be destroyed. In lieu of this, any necessary time limits on data withdrawal were made clear to participants from the start (BPS, 2014). Moreover, participants were ensured that all data was anonymised and could not be traced back to them (BPS, 2014; HCPC, 2012) and were offered the opportunity to review their individual transcripts for accuracy and anonymity (Smith, Flowers & Larkin, 2009).

The interviews had the potential to be distressing for the participants and, therefore, I engaged in a debriefing process where participants had an opportunity to discuss anything they found difficult. It was of ethical significance that I explore potentially distressing experiences or memories, limiting the potential for participants left vulnerable in ways that they were not prior to the interview (Shaw, 2010). Although they were a professional group, and therefore neither clinically nor socially vulnerable, I had contact information readily available for further support if necessary. See Appendix VII for the complete Debrief Schedule.

My role as a reflexive researcher introduced a need for further ethical considerations. It was paramount that I respect the knowledge, insight, experience and expertise of participants (BPS, 2014). Therefore, I continually attempted to confront and interrogate my own prejudices, to move beyond them and subsequently incorporate them into my understanding (Shaw, 2010). I was aware that my own lack of awareness could detract focus and serve to lose richness from the participants'

accounts (Shaw, 2010). Shaw (2010) further describes the significance of using a reflexive approach in experiential qualitative research:

“Through making ourselves aware of our own feelings about and expectations of the research we can begin to fully appreciate the nature of our investigation, its relationship to us personally and professionally, and our relationship as a researcher and experiencer in the world to those with whom we wish to gather experiential data. By engaging in reflexivity, that is, proactively exploring our *self* at the start of our research inquiry, we can enter into a dialogue with participants and use each participant’s presentation of self to help revise our fore-understanding and come to make sense of the phenomenon anew” (p. 235).

One can only understand another’s presuppositions, beliefs, and predilections once one’s own have been made transparent (Gadamer, 1975/2013). IPA embraces a double hermeneutic that supports the adoption of a reflexive attitude in which self and other are examined as part of the research process (Shaw, 2010), which lays at the heart of the proposed research study.

Interview schedule

To maintain the openness required for such exploration, I incorporated guidelines offered by Smith (2015) and Smith et al. (2009) into the design of the interview. The questions for the interview schedule were developed as a result of my own experience of personal therapy and clinical practice, discussions with colleagues, and from reading the existing literature on personal therapy and CBT. The interview schedule (see Appendix VI) included questions such as: Do you feel that your personal therapy has influenced your CBT clinical practice? Can you think of a time in clinical practice when you were aware of your personal therapy? Do you feel that your personal therapy has been influential in maintaining effective therapeutic relationships?

Interviews lasted between one and one and a half hours and took place in a conveniently located and comfortable setting of participants' choosing: at their homes, private offices, consulting rooms or at the University of Roehampton research rooms. Interviews were audiotaped with consent and, when appropriate, departed from the interview schedule guided by the participants' contributions (Kvale, 1996; Smith & Osborn, 2015). Interviews were then transcribed verbatim. Participants were offered the opportunity to review their transcripts. Following one of the interviews, I and a participant together agreed to a follow-up interview to further the detailed account of their individual experience.

Analysis

Interview transcripts were subject to IPA, suitable to my aim of adopting an insider perspective as far as possible into participants' worlds (Mulveen & Hepworth, 2006). As mentioned earlier, in agreement with IPA I rejected pre-existing hypotheses prior to conducting the research and, rather, focused the analysis on themes that emerged from participants' accounts to create new theoretical frameworks (Rizq & Target, 2008b).

Following the approach outlined by Smith et al. (2009), individual analyses were conducted separately, one interview transcript at a time. I repetitiously read through each transcript, made initial notes (see Appendix VIII) and listed individual themes and subthemes (see Appendix IX) before moving on to the next transcript. I developed detailed notes on three levels: descriptive (i.e. content), linguistic (i.e. language use or linguistic style) and conceptual (i.e. personal reflections). The first

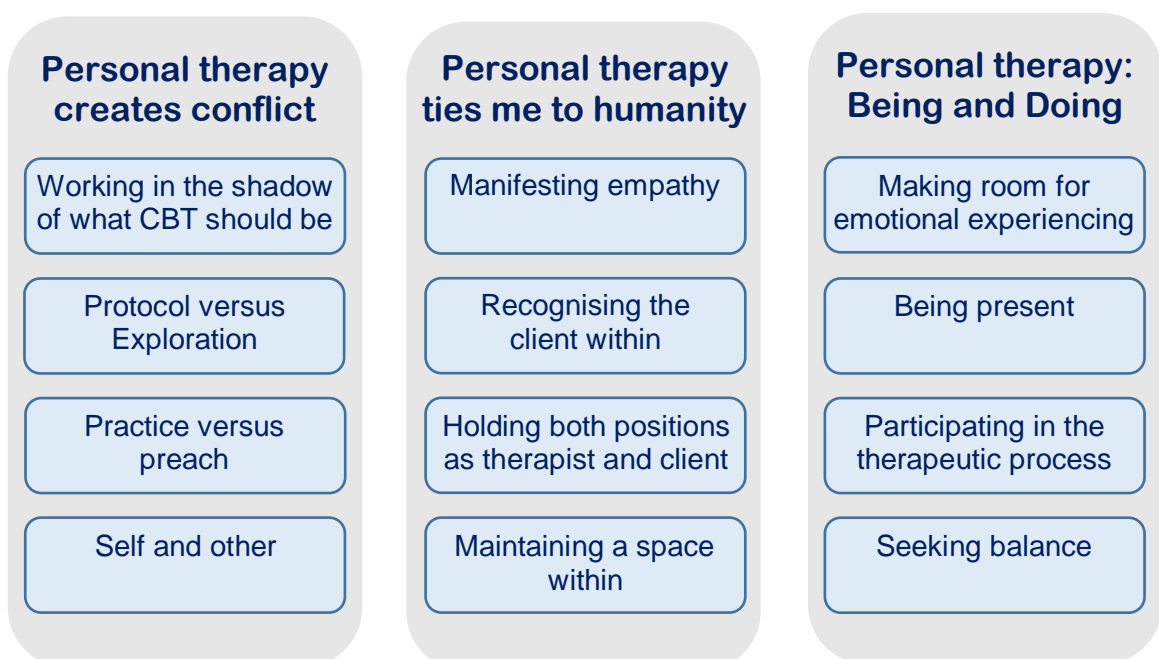
level, descriptive coding, required the identification, description, and understanding of two related, yet distinct, aspects of participants' accounts: the 'object of concern' in participants' worlds and the 'experiential claims' made by participants (Larkin et al., 2006). IPA requires an in-depth exploration of individual experience and meaning creation prior to exploring patterns and themes across individuals (McMahon, 2012). Therefore, I developed a framework for building themes with subthemes, supported by the verbatim text from the transcript. This process was repeated for each transcript as if each were my only piece of data. Once I had sufficiently analysed each transcript individually, I contacted participants to ask whether they might like to review my analysis of their transcript. Five out of the seven participants responded. Three out of the five participants who responded reviewed and approved the individual analysis.

I then began to cross-analyse by looking over all the transcripts as a whole with consideration for how themes might merge. Throughout this process, I continuously referred back to each individual transcript to ensure the emerging master list of themes and subthemes remained justified within the data. Guidelines for ensuring rigour in qualitative research were followed to establish a quality of control framework (see Mays & Pope, 2000; Morse, Barrett, Mayan et al., 2002). The analysis process was recorded in detail to enable the Director of Studies to conduct a validity check (Yardley, 2000, 2008). Furthermore, the completed analysis was presented to the London Regional IPA Group to confirm that the analytic process and identified themes were credible and justified.

ANALYSIS

Interpretative phenomenological analysis of seven interviews resulted in the identification of three master themes, with 12 subthemes. In this chapter I explore these themes in detail. This analysis is my account of CBT therapists' experiences of personal therapy in clinical practice, and I acknowledge that different researchers could have focused on different aspects of participants' experiences.

Each theme is presented with supporting verbatim extracts from participants' accounts to help clarify and illustrate themes. Some minor amendments have been made for ease of reading. In quotations, material that has been omitted is indicated by ellipsis points '...' All identifying information has been eliminated to ensure anonymity, as previously discussed in the Methodology chapter. The analysis resulted in 12 interrelated subthemes grouped into three master themes presented below:



Master Theme 1: Personal Therapy Creates Conflict – “...it’s led me astray”

(Peter, Transcript 1, p. 8, line 158).

All participants were painfully aware that the way they practiced CBT in their clinical work bore little resemblance to what they described as ‘mainstream’ CBT. It seemed as if participants felt that their clinical practice had been ‘led astray’ by the personal therapy they had themselves received, deviating from what many seemed to hold up as an idealised image of a standardised and sanitized protocol-led CBT. For example, participants similarly valued a process of ‘exploration’ gained from their personal therapy, however also seemed to share the concern that this very process they valued was undermined by the protocols they felt pushed into following. As a researcher my impression was that the aspects of personal therapy participants had found helpful to their clinical practice clashed with their identity as CBT therapists. It seemed as if being a conventional CBT therapist meant adhering to one standard without the space for individuality and flexibility, which further appeared to reduce CBT to a collection of techniques rather than a flexible form of therapy.

Working in the shadow of what CBT should be

All participants recounted experiences of delivering something more, or different, to ‘pure CBT’ in their clinical practice. This not only seemed to suggest that participants held an idealised view of CBT but also conveyed a shared sense of paradox by which personal therapy seemed to equip participants with therapeutic tools that paradoxically hindered their capacity to practice what they described as ‘pure’ CBT. It was clear that all participants felt they benefited from their personal therapy, both personally and professionally, yet also seemed to share the sense of being

contaminated by their personal therapy. My impression was that the CBT model had been illustrated as ‘pure’ and antiseptic, a model that participants felt they had infected with their experiences of personal therapy. Four out of the seven participants specifically described their integration of personal therapy and clinical practice as an ‘act of deviancy’, suggesting a shared belief that CBT is some kind of ‘norm’ from which they are continually diverging. This appeared to facilitate participants’ shared sense of being ‘led astray’ from their belief of a conventional CBT model in which they *ought to* follow strict protocols.

For example, Dorinda conveys her sense of being ‘led astray’ by her personal therapy when describing her clinical practice as, “completely almost pure CBT but...”, which suggests her sense of divergence from a ‘pure’ CBT model in which she must follow protocols ‘completely’:

“...it’s completely almost pure CBT protocol but really influenced by just a little tiny bit of psychodynamic thinking that, sort of, I gained from looking at my own processes, looking at, at a, my own therapy, what I re-enact from the past” (Dorinda, p. 5, line 101).

Peter similarly discusses how he has gradually come to depend less on CBT as an established set of protocols, instead using a CBT framework as a more flexible guideline from which to follow the client’s lead. However, Peter’s use of the word ‘deviating’ is suggestive of a feeling that he is somehow departing from the usual, accepted standards of CBT:

“For me protocols now—as a result of the, uh, personal therapy, protocols are a guide, but they’re not a must...I’m quite capable of deviating slightly”
(Peter, Transcript 1, p.7, line 146).

Peter then further compares his clinical practice to his belief in an ideal CBT practice, which seems to illustrate his sense of conflict between his clinical practice and the ‘rigid’ CBT model from which he deviates. Peter appears to personify the CBT model as an exclusive group governed by one accepted standard, a group from which he seems to feel rejected:

“Now some would say, ‘this is a disaster, that doesn’t do the trick’. Um, but I tend to feel this helps clinical practice...So you could say, from a rigid CBT point of view, it’s led me astray” (Peter, Transcript 1, p. 8, line 151).

Like Peter, Sandra also personifies the CBT model, however as an ‘institutional supervisor’, comparing her clinical practice with what her supervisor might say, as if having to choose between her own clinical intuition and the CBT model. She seems to dismiss the institutional expectations of the CBT model she perceives for the sake of her clients. However, she also appears to manage a sense of rejection from her internal supervisor, the part of herself that holds her clinical practice at constant comparison with a standardised CBT model:

“I practice...therapy in the way that I think would be beneficial to the client rather than being too worried about what my...institutional supervisor might say” (Sandra, p. 12, line 270).

Raul similarly compares and, even, distinguishes his clinical practice from the conventional CBT model he perceives to be based on specific ‘formula’. As with

Dorinda, Peter and Sandra, this suggests a possible conflict between Raul's clinical practice and the image of a more 'mainstream' CBT. Yet it seems as if his willingness to tolerate the conventional CBT approach warrants his own clinical validation of his alternative way of practicing CBT:

“But that's really working to a, to the formula...and if that's your target and that's your goal, which is absolutely legitimate and nothing, nothing wrong with it, um, uh, then that's what you do but uh, uh, uh, it's not, it doesn't have the same components that, uh, the work that I would seek to do, which is to help people understand who they are” (Raul, p. 12, line 241).

Participants seemed to describe their clinical practice against the backdrop of a CBT 'norm', which appeared to be illustrated as a clean and uncontaminated clinical template against which their rather messier personal therapy experiences intrude and about which they seemed to feel guilty. It was as if they had held their own way of practicing CBT in a constant state of comparison with a CBT model they perceived to be governed by one accepted standard, a standard they had failed to uphold.

Participants demonstrated a shared feeling of having committed wrong, which seemed to elicit a need to justify their clinical practice, to prove themselves as CBT therapists.

Protocol versus Exploration

All participants distinguished between a personal experience of therapy as a journey of exploration and discovery and the somewhat different experience of delivering a protocol-led CBT to their clients. The long and difficult process of personal change and development experienced and valued by participants seemed to conflict with the pre-determined code of procedures proposed by the CBT model they practiced. Five

out of the seven participants appeared to share the belief that the strict adherence to protocols expected of them as CBT therapists served to hinder aspects of therapy essential to their clinical practice.

For example, Peter appears to have struggled with the protocol-driven CBT model he once felt pushed into following and which he has gradually come to depend less upon in favour of a more 'relational' model. Below, he describes his early 'treatment failures' as relying too heavily on CBT protocols, like a machine, which hindered his capacity to subjectively engage with clients; a relational aspect of therapy he finds essential to his clinical practice:

“Certainly, some of my, inverted commas, treatment failures, I’ve actually been too heavy on a, the sort of delivery protocol...I appear at times mechanistic, and I’ve sometimes thought, *oh god I didn’t really relate to that person at all*” (Peter, transcript 1, p. 21, line 431).

Dorinda similarly discusses her struggle to balance her sense of pressure to follow the CBT protocols with her belief of the benefits of a deeper, less content-driven therapeutic exploration of clients’ feelings. She describes her experience with clients who appear to prefer to distance themselves from, and hand over, their problems for her to manage. She likens her role to that of a ‘medical doctor’, which seems to illustrate an objective, content-driven, problem-solving focused treatment and, furthermore, appears to illuminate her struggle to offer a subjective, process-driven, explorative treatment where feelings of anxiety can be tolerated:

“...they come in, and they go *woosh* ‘Here’s all my stuff, you deal with it.’ And, and then you kind of diagnose and, and you treat. So very medical

model. Doctor my foot is hurting. But I'm much more aware that...there is a whole host of anxieties before you even enter the therapy room...that CBT doesn't have space for" (Dorinda, p. 14, line 342).

Charlotte, too, describes her own experience of feeling encumbered by the CBT model's protocol-driven expectations. It is almost as if Charlotte finds that the CBT model hinders her from making contact with her client's emotional distress. She struggles with what appears to be a choice between sticking to the CBT approach or listening more deeply to her client:

"...if I continued with my structured sort of way...I would've completely overlooked [my client's] needs and what was so alive in the room, which was she wanted me to sit and allow her to be and for me to actually hear what—her pain" (Charlotte, p. 15, line 360).

Below, Raul more overtly distinguishes between his views of therapy and 'mainstream' CBT and appears to reduce CBT to a collection of protocols as opposed to a form of therapy. His distinction between 'therapy' and 'CBT' seems to illustrate his need to diverge from the strict application of CBT protocols to facilitate 'an exploratory operation':

"But I don't really regard CBT as therapy. Um I regard CBT as the application of evidence-based protocols to specific problems. That isn't my definition of therapy. I see therapy as a much more of an exploratory operation" (Raul, p. 4, line 72).

Participants' distinct experiences of personal therapy and clinical practice seemed to reveal a greater distinction between the personal therapy they received and the

therapy they practiced; between the respective functions of therapy as a journey of exploration and discovery and of therapy as a delivery of specific problem-solving protocols.

Practice versus Preach

There appeared to be a particular tension for participants between the notion of therapy for a particular problem and a therapy that aims to enhance growth and development. Three out of the seven participants described their personal therapy as a way ‘to better myself’, ‘enhance wellbeing’, and ‘to improve my life’. In contrast, participants portrayed CBT as a ‘goal-driven’, ‘crisis intervention’ meant to help overcome the sense of self-defeat. This striking difference between the therapy participants sought and the therapy they delivered appeared to illustrate a fundamental divergence of attitude between undergoing therapy due to an urgent sense of desperation and undergoing therapy due to a more casual sense of desire.

For example, Dorinda identifies CBT as “fantastic at a crisis” (p. 11, line 234) and further describes it as a professional intervention meant to help people in urgent need. In contrast, Dorinda appears to seek personal therapy for her own personal desire to enhance ‘myself’:

“Because when I go to therapy, I don’t go to therapy for a point of, ‘My life is not working out and I need help’. So I don’t go to therapy from a sort of mental health crisis point of view. I go to therapy as a way of self-discovery. Making myself, eh, just a better person for *myself*, not for anyone else” (Dorinda, p. 11, line 238).

Similarly, Raul differentiates between his personal experience of therapy as a means of enrichment and his belief in the more common approach to CBT therapy as a means to overcome a specific problem. Furthermore, it is my impression that Raul's portrayal of life as 'traumatic' serves to normalise his more casual use of therapy:

"I'm in personal therapy for richness...I'm not working on any particular um, um, uh, uh, traumatic issue apart from life" (Raul, p. 20, line 411).

Hank more overtly explains his use of a less goal-driven personal therapy as a means to counterbalance the goal-driven nature of his clinical practice. In this way personal therapy appears to offer Hank a sense of balance:

"The payoff is I'm goal driven in my sessions but then when I go to my own personal therapy it allows me to just, just be... but with my, with the client base that I have it's not about just being, it's about working towards the goal. And that's why they come to see a cognitive therapist rather than someone else" (Hank, p. 21, line 446).

The difference between the therapy participants' sought and the therapy they delivered seemed to elicit a sense of distance between themselves as clients and their clients. Participants' use of their own personal therapy appeared different from their clients' use of CBT. Yet as therapists, participants' experiences of personal therapy modelled the flexibility and openness that seemed to enhance their capacity to connect with, and relate to, their clients' unique qualities; bridging the gap between self and other.

Self and Other

The more participants learned about themselves the more they seemed to allow themselves to relate to their clients. Participants appeared to use their personal therapy to become aware of their own feelings and to share themselves as a part of their clients' experiences. Personal therapy seemed to facilitate participants' capacities to assume a clinical responsibility to think about what had gone on between them and their clients. Five out of the seven participants conveyed that their own self-awareness allowed them to get involved, and connect, with their clients' experiences in therapy. The following extracts appeared to illustrate participants' capacities for reflexivity, which further seemed to illuminate a fundamental relationship between self and other in clinical practice.

For example, Charlotte recounts the first time she becomes aware of her potential influence on her client. Her experience seems to illustrate a shift from a clinically objective process by which she keeps herself out of, or separate from, her client's experience, to a subjective process by which she considers and shares herself as part of her client's experience:

“...I started thinking about, um, the feelings that are being, you know, that are experienced in a room, how much of it is the client's, how much of it is mine”
(Charlotte, p. 8, line 179).

Hank similarly recounts his own experience of becoming aware of his feelings in relation to his client, and describes what appears to be a confusion between his own and his client's 'anxiety':

“...I took on [my client’s] anxiety, and I brought that to therapy to sort of look at that, that, that I had her anxiety...that’s where therapy will help you or help me sort of move forward, um, where I can just go, *okay let’s just pull the bones out of something*” (Hank, p. 20, line 424).

Raul also reflects on how his personal therapy directly impacts his clinical practice by facilitating his capacity to think about what is going on between him and his client.

Raul seems to describe a clinical process by which he uses his personal therapy to explore the emotional impact of his clinical work:

“...I dealt with it in personal therapy because I was really wiped out by it. Um, I just felt completely, uh, um, uh, um, annihilated by the process, um, and that was very helpful because I was able to put it into place and to think, well, you know, *what was actually going on?*” (Raul, p. 23, line 472).

Karly takes it a step further by discussing how she uses her self-awareness to inform her therapeutic interventions. In the following example, she describes how she is not able to select between different clinical interventions on the basis of how she herself is feeling with her client. Karly’s openness to the choices available to her seems relevant to the topic of subjective engagement discussed earlier in the subtheme, ‘Protocol vs Exploration’, with Peter. Like Peter, Karly’s prime concern seems to be about how she relates to her clients and appears to demonstrate her clinical capacity to take responsibility for her own motivations:

“I’ll think, *what’s my motivation? Am I trying to prove that I’m a good therapist? In that moment, what’s going on for me? Am I feeling vulnerable? If I’m feeling vulnerable, is it my vulnerability? Is it their vulnerability?* So all of that has to happen really quickly as a therapist in your, in those

nanoseconds when it whizzes through your brain. And then it's within, it becomes a choice as to whether I then make an informed intervention" (Karly, p. 24, line 597).

Whilst personal therapy appeared to conflict with many aspects of the 'mainstream' CBT model as perceived by participants, the very aspects that clashed with their identity as CBT therapists seemed to inversely tie them closer together with their clients. Personal therapy seemed to facilitate a space for individuality and flexibility fundamental to participants' clinical practice. Although perhaps messier, their capacities to 'use the self' to take responsibility for their own feelings and vulnerabilities appeared to strengthen participants' capacities to tolerate the feelings and vulnerabilities of their clients.

Master Theme 2: Personal Therapy Ties Me to Humanity – "You know, you've got to be kind of human" (Raul, p. 29, line 591).

All participants spoke about their feelings and vulnerabilities in ways they seemed to consider a 'normal' part of 'being human'. Their shared sense of 'being human' appeared to convey a transparency by which participants seemed open to their own emotional complexities and to connecting with their clients' unique complexities, as opposed to, perhaps, considering themselves to be void of emotional conflicts and unlike their clients. Nonetheless, some participants described a struggle to 'be human' as therapists, under pressure to remain emotionally unaffected by their own life experiences, which suggested the presence of a divide between therapists (the unaffected) and clients (the affected). 'Being human' seemed to include vulnerabilities and problems that, as therapists, they felt they should not have.

However, participants' experiences as both clients and therapists appeared to bridge this gap and seemed for many participants to sponsor an experience in which two humans could share a therapeutic space. Many participants reflected on their positions as both client and therapist, moving between both positions and drawing from both their experience *with* clients as well as their experience *as* clients, to better understand their clinical experiences. It seemed as if participants were suggesting that drawing from their own experience to understand their clients' experiences enabled them to forge fundamental connections based on the shared experience of 'being human'.

Manifesting empathy

All participants demonstrated a capacity to understand and share the feelings of their clients. Knowledge of their own vulnerabilities and emotional sensitivities seemed to facilitate a process of empathy by which participants and their clients could find common ground. The underlying commonality of being human, of being in therapy and of being familiar with the emotional burdens of life, seemed to enable participants to meet their clients where they are, to help tolerate and work through their clients' suffering. Offering themselves to their clients in this way appeared to illustrate a strong connection between them, in contrast to, perhaps, the distance created when one feels pity for another's misfortune. Participants seemed to be familiar with their own misfortunes and used their familiarity to be more relatable to their clients.

For example, below Hank speaks about how his personal therapy 'helps me be okay with my clients', and appears to demonstrate a parallel process by which his enhanced self-acceptance facilitates his acceptance of his clients. Furthermore, his capacity to

draw from both his positions as client and therapist seems to enhance his capacity to position himself by his client and participate in his clients' clinical experiences:

“...my personal therapy would help me to, to be okay with the reality of where my clients are at, um, which allows them to live their lives as they need to...it's sort of normalising life and not making it, um, this big scary thing” (Hank, p. 17, line 369).

Similarly, Dorinda reflects on how personal therapy enhances her capacity to empathise with clients, and demonstrates her capacity to share an emotional space with her client; to keep her client in mind while also moving between her positions as both therapist and client, to make sense of complex clinical experiences:

“...I just kind of make sense of it in therapy for me and...I will also talk about it when the client is in mind. So it's not just about me...it's me wanting to discuss whatever touched me but at the same time, uh, having the client in mind (Dorinda, p. 6, line 120).

Karly more specifically recounts a complex clinical experience when her client's issues touch on her own. Drawing from both her experiences as therapist and client, Karly attempts to facilitate an alternative experience to 'what always happens'. By allowing herself to be affected by the experience, she appears to make greater effort to be a part of her client's experience, and works alongside her client to co-facilitate an alternative outcome:

“...the client wanted to just end...and I said, *no...you're going to come back and we're going to look at this, and we're going to reflect and understand and*

be together in this ending... we're not going to do what always happens in both their life and my life" (Karly, p. 10, line 235).

Six out of the seven participants spoke about how their experiences as both therapist and client facilitated their capacity to be affected by their clients and to use their own feelings to be more receptive to their clients' experiences. Participants' reflections demonstrated a clear distinction between the notions of *empathy* and *sympathy*, by which participants were open to sharing a parallel experience with their clients rather than separating themselves, the unaffected, from their clients, the affected.

Recognising the client within

All participants spoke about their experiences of recognising the client within themselves and appeared to demonstrate a clinical capacity to identify something in their clients after having encountered it within themselves. It seemed as if self-knowledge was used by participants to monitor their own experience; to use themselves as tools to respond to clients; and to sense how their responses impacted their clients. Participants seemed to share a sense of having 'been there' as clients, which appeared to facilitate their sensitivity as therapists. In some cases, it seemed that participants had modelled in clinical practice that which they had received from their own therapist in personal therapy. Allowing themselves to identify with their clients in this way appeared to demonstrate a heightened sense of sensitivity, receptivity and respect.

For example, Sandra speaks about her own experience of needing to cry in her therapy and how this has influenced her capacity to recognise and tolerate crying in her client. Identifying with her client in this way appears to influence Sandra's

capacity to be receptive to her client's needs, rather than block her client's process to ameliorate her own discomfort:

“And I have it out not to engineer and interrupt because I have been through that experience and I recognise the importance of their need to cry for, for, for fifty minutes and that's okay and my being silent and that's okay. So I'm more comfortable, I'm comfortable with that” (Sandra, p. 12, line 266).

Dorinda similarly describes a parallel therapeutic process by which her experience of being observed and tended to in personal therapy enhances her capacity to be observant and attentive towards her clients. Furthermore, Dorinda's admission to ‘just think it to myself’ serves as an acknowledgement of the CBT model she follows, which does not involve discussions of ‘unconscious processes’, and appears to illustrate the significance of her ‘notice’:

“But I might just think it to myself. You know, *which unconscious unconscious process did it trigger? What am I noticing that is your blind spot*, as a therapist? And why I notice that blind spot, mainly because I've been there. I had, I've got my own blind spots” (Dorinda, p. 14, line 316).

Like Sandra and Dorinda, Hank, too, draws on his own experiences of ‘being there’ as a client to reflect on his clients' experiences in therapy, and seems to use himself as a tool, to model his own learning, to relate to and connect with his clients:

“...most people don't like to admit when they're wrong...and, you know, if I get it wrong it's okay to say it. That's part of learning. It's about saying, *okay, I got that wrong, you know, it's okay the world is not going to stop*” (Hank, p. 14, line 298).

Below, Peter's capacity to reflect on his early experiences of emotional difficulty offers him insight into his clinical practice. Although he had not undergone CBT himself, his ability to draw from his own experiences as a client seems to facilitate his sensitivity as a therapist to his clients' emotional difficulties and the great relief therapy can offer:

“My early years were very sort of isolated...and full of awkward emotions like shame...and, so CBT comes along and provides a very explicit template, which enables one to actually say, *well this is how emotions happen*” (Peter, transcript 2, p.1, line 23).

All participants felt that their positions as clients were essential to their clinical practice and offered them insight they otherwise could not attain. The ease in which they could be like their clients seemed to support a notion of common humanity. Yet, this also seemed to reveal a sense of unease as if, as therapists, participants should not be like their clients.

Holding both positions as therapist and client

Participants all conveyed a curious paradox: on the one hand, they described the importance of simultaneously occupying the position of both therapist and client; and on the other, they appeared anxious about their role as clients, almost as if emotional difficulties were deemed to be unacceptable in therapists.

For example, Peter appears to accept his emotional difficulties as a ‘normal’ part of being human. However, according to Peter, what is accepted as ‘normal’ for clients is not necessarily accepted as ‘normal’ for therapists:

“It’s just a bit of my life that hasn’t been quite normal. I mean it’s normal to be fucked up but, you know, it’s not the normal thing you’ve, I think you’d expect counsellors to have had” (Peter, Transcript 2, p. 6, line 137).

Having the same feelings and psychological issues as a client evokes a feeling of panic in Charlotte. Like Peter, Charlotte speaks about her fears of having emotional problems as a therapist, and seems to suggest that therapists who suffer emotionally are unfit for practice:

“...she was depressed, and she started talking about her struggle....as she was talking I, I just had this moment of panic, like, *god she’s describing me!* You know, she’s talking about *me*. And then I think I really panicked because I thought...how can I help her when she’s describing *me* as her *problem*” (Charlotte, p. 9, line 204).

Karly seems to use her position as a therapist to challenge herself as a client. Her capacity to relate to her clients’ issues appears to serve as her motivation to work through her own, which she further finds to be crucial to her development as a therapist:

“CBT is absolutely pivotal in challenging my own issues, my own relationship with anxiety—with anything. Anxiety, depression, mood, eating, you know, all the different aspects that come in through the door” (Karly, p. 6, line 138).

Hank similarly considers the transcendent influence of his emotional development. His capacity to acknowledge and take responsibility for his own issues facilitates his capacity to be ‘open’ with his clients. Furthermore, Hank’s reference to therapists and humans as the same translates his process of therapeutic connection to a process of human connection by which he works through his own ‘stuff’ to allow access, and make room for others, within himself:

“As a therapist or as being a human being, I think if ...you understand and own your own stuff you can be more open with other people the same way you can be with a client (Hank, p. 12, line 247).

Maintaining a space within

All participants spoke about a shared therapeutic ‘space’ within themselves that they reserved for their clients. This notion appeared to illustrate a psychologically hospitable area located inside what might be described as participants’ ‘souls’: a mental space of emotional holding, capable of offering support and succour to clients. My impression was that participants conveyed a shared sense of being at their client’s disposal and appeared to provide their clients with an emotional and spiritual safe place where their clients could begin to discover themselves. It appeared that the fundamental connection participants managed to forge with their clients depended on the relationship they established with themselves. On one level, participants spoke of offering to their clients that which had been offered to them as clients. On a deeper level, participants seemed to call upon their own vulnerabilities to use themselves as clinical tools to better understand and tolerate their clients.

For example, Dorinda acknowledges her capacity to use and share a space inside herself, where she has been made aware of her own suffering, to allow for, and embrace, her clients' suffering. This appears to illustrate a parallel process by which Dorinda's experience of conveying and expressing her suffering to another prepares her to be receptive to her client's suffering:

“‘Cause I’m kind of aware of my own suffering, but I’m also aware of the person who’s coming suffering. ‘Cause I spoke about my own suffering in my own therapy....so I’ll have a lot of space for that” (Dorinda, p. 17, line 374).

Similarly, Sandra recognises a ‘space’ within herself that she is able to offer clients ‘in need’. Her capacity to reflect on her own experience as a client ‘in need’ and the ‘generosity’ she received appears to facilitate her capacity to offer her clients a similar hospitality within herself, sourced by benevolence and beneficence:

“...because I had that sort of generosity experience, that generosity at a time of need, I also feel it would be nice for me to offer it to someone” (Sandra, p. 9, line 200).

Hank, too, refers to a hospitable space inside himself that is meant for sharing with his clients. His reference to ‘sitting’ with his clients might be seen as a metaphor for the internal home in which Hank invites his clients to ‘pour their hearts out’. There is also a sense of familiarity that emerges from this extract as if Hank knows what it is like for his clients because he has ‘been there’, too. Hank’s hospitality appears to illustrate an area within himself where he can tolerate his own, as well as, his clients’ vulnerabilities:

“You are building a relationship with a client because they’re sitting there with you and are about to, um, sort of pour their hearts out and tell you their life story” (Hank, p. 11, line 227).

Raul describes how his capacity for self-awareness serves to enhance his sense of tolerance for his clients’ uniqueness. This reciprocal process appears to illustrate a sense of hospitality within Raul where he can move out of the way to allow his clients to become more visible. Therefore, by sharing his hospitality, he appears to become more aware of his clients’ unique qualities:

“It’s the use of the self. And the more you are aware of how you are as a person, I think, the more you are aware of how the other is as a person and the more you can see what’s going on for the other” (Raul, p. 28, line 583).

Participants’ experiences of ‘using the self’ seemed to highlight the significance of their personal therapy in sharing a common ground with their clients. Their capacity to tolerate their clients’ difficult emotions appeared to rely on their capacity to tolerate their own. Participants seemed to call upon their own vulnerabilities to forge fundamental connections with their clients based on the shared experience of being human. It was clear that they all valued ‘being’ with their clients in this way, however, found it difficult to determine its worth within the goal-driven, ‘doing’-focused nature of the CBT framework.

Master Theme 3: Personal Therapy: Being and Doing – “...by doing you’re also...you’re being as well. It’s, it’s sort of marrying those two together” (Hank, p. 23, line 505).

The ‘marriage’ of being and doing described by participants illuminated a distinction between a therapeutic emphasis on being experienced in their personal therapy and the therapeutic emphasis on doing prioritised in the CBT model they followed.

Participants found that their roles as therapists relied on their capacities to both *be* and *do*; however they often struggled to find the space ‘to just be’ in the action-focused, goal-orientated CBT model they perceived. In light of this difficulty, five out of the seven participants spoke about their efforts to keep a balance between ‘being’ and ‘doing’ in their clinical practice. Participants believed that the spiritual and emotional safe place they provided served to facilitate their clients’ capacities to reach their therapeutic goals, yet it remained difficult to explicate *how*. This difficulty further appeared to reveal a lack of space within the field for participants to think about and discuss experiences of ‘being’ outside of their personal therapy.

Making room for emotional experiencing

Four out of the seven participants referred to the value they placed on allowing their clients ‘to just be’, a seemingly ‘foreign’ concept to the CBT model, which instead they found focused more on achieving ‘goals’. Participants collectively described the CBT model as a therapeutic process revolved around ‘expectations’ and ‘procedures’ that could ‘distract’ and leave little room for clients’ emotional experiencing.

Therefore, participants seemed to have to go ‘off-track’ from their CBT practice to prioritise their clients’ emotional experiences.

For example, Peter talks about being open to his client's requests to go 'off track' from his 'procedure'-led clinical practice. It seems that Peter's experience of personal therapy facilitates his clinical capacity to follow the CBT model with flexibility, to feel more comfortable veering off the session goals and in tolerating his clients' emotional experiences:

"If they don't want to go a particular way, I'm very easy going about that. That doesn't worry me. 'You don't have to do this procedure, let's just talk', you know, I've got all that. And I think I gained that from doing these very different therapies, which were invitational in nature" (Peter, transcript 1, p. 7, line 134).

Unlike Peter, Sandra struggles with the expectations she encounters in working with a tearful client under the CBT model. Her metaphor of a CBT 'supervisor', which you might remember from the subtheme, 'Working in the shadow of what CBT should be', appears to illustrate her internalised sense of pressure to achieve goals and to stick to an agenda that is not always relevant to her clients' experiences. Sandra's predicament seems to demonstrate her sense of having to choose between the CBT model's expectations 'to do more' and her clinical intuition:

"It's probably hard to tell your supervisor, 'I just let the person cry for the entire fifty minutes'. It's almost like a, well you need to do more...to move towards the goal of using their scores...there are a certain set of expectations associated with what you achieve" (Sandra, p. 12, line 260).

Charlotte similarly speaks about her struggles of working under the CBT model, which she seems to see as an obstacle in the way of allowing clients 'to just be'. Her

views of the CBT model's priorities to take action and challenge thoughts seems to work against the self-acceptance she aims to facilitate in her clinical practice.

Charlotte appears to find it difficult to integrate a space for emotional experiencing into the CBT model she perceives and, like Sandra, senses her need to choose between the CBT model and her clinical values:

“...the space for a person to just be and, um to just accept, you know, rather than trying to distract themselves or run away from it or correct their thoughts or their pattern of behaviour.” (Charlotte, p. 12, line 283).

Dorinda believes that her personal therapy has made her more aware of the implicit feelings indirectly expressed by her clients. However, she struggles to reveal these ‘anxieties’ in her clinical practice, which she finds, quite simply, ‘CBT doesn’t have space for’:

“But I’m much more aware that the people who come through this door find it sometimes very difficult to talk, there is a whole host of anxieties before you even enter the therapy room... You know, that kind of thing. That that CBT doesn’t have space for” (Dorinda, p. 14, line 344).

Being present

Participants spoke about their experiences of working with implicit communication in their clinical practice, such as of handling or containing feelings indirectly expressed by their clients. However, incorporating an understanding of implicit communication into the explicit template of the CBT model appeared to be difficult for some participants. Four out of the seven participants considered how their experiences of *being present* with their clients, to ‘attend’ to, and ‘attune’ to, their clients’ implicit

communications, served to benefit their clinical practice. Participants' accounts appeared to illustrate an intricate process of 'tuning in' to their own experiences while simultaneously staying with, and responding to, their clients' experiences. Existing *in* sessions *with* their clients in this way seemed to allow participants to be guided by their clients and to contribute more extensively to a shared clinical experience.

For example, below Sandra recounts feedback she had received from her client, who felt that she had provided him with an 'individualised' treatment. Sandra considers that her capacity to 'attend' to her client facilitates her capacity to provide a standardised treatment in a way that feels individualised. Sandra's experience appears to illustrate her participation in her client's clinical experience in a way that maintains a shared sense of connection:

"I wasn't inventing new interventions that have never been used but I guess perhaps there was this attending to, taking hold of all, all the different issues and, um, perhaps him having a sense that I am connected to him" (Sandra, p. 18, line 382).

Charlotte more specifically recounts her experience of putting aside her CBT protocol in order to follow her client's lead. It seems that her awareness of her preoccupation with the CBT protocols facilitates her ability to redirect her focus to her client. This process appears to demonstrate Charlotte's clinical capacity to use her self-awareness in the session to prioritise and stay connected to her client:

"I sort of put all the paper and everything away and I just sat. And I, um, and she cried, very much so, and she talked, um and I felt that that's exactly what she needed there and then" (Charlotte, p. 15, line 354).

Karly similarly speaks about her efforts to ‘bracket off’ her own thoughts, opinions and judgements from her clients, to be more open to, and explorative of, her clients’ experiences. This process appears to demonstrate Karly’s clinical capacity to simultaneously engage with both her experience and that of her client, which seems to create a shared clinical experience:

“I’m very aware of my own frame of reference sometimes coming into the room and how to bracket that off so how to really think about it, this is how I think about it, but stay with the client, stay with the client’s material in terms of how do they understand it, how they make meaning, what is the significance in their life?” (Karly, p. 6, line 134).

Hank more explicitly refers to his use of personal therapy to attend to his client who struggles to stay ‘present’. Hank seems to identify with his client’s difficulty and draws upon his own therapy to facilitate his own capacity to be ‘present and focused’. By tuning in to his own experience Hank manages to stay with and take part in his client’s experience:

“...I have one client in particular...he comes in here and...he’s already, he’s had his session...So I have to bring him back to right now to where we are *right now*...And so for that to happen I also need to be present and focused. So that’s when my personal therapy comes in. It helps *me* to be there and do that” (Hank, p. 43, line 512).

Participating in the therapeutic process

Participants’ involvement in their clinical practice implied more than a protocol-driven notion of therapy, in which they drew from their own experiences to better

understand their clients and to forge fundamental connections with them. Participants both consciously and unconsciously appeared to draw upon their personal therapy in their clinical practice to facilitate their more intimate participation. All participants spoke about their clinical practice in a way that seemed to involve them as integral parts of the therapeutic process alongside their clients. Their personal sense of involvement appeared to illustrate participants' openness to being affected by their clients.

For example, Charlotte speaks about her experience following a session in which she suffers from symptoms similar to her client. Charlotte seems to first become aware of her own personal experience before connecting it to the symptoms her client had presented earlier that day, illustrating her very personal sense of involvement in her client's experience. This appears to demonstrate Charlotte's capacity to participate in her client's experience by tolerating her client's occupation of her:

“...I start noticing that my hand starts sweating and...my heartbeat was sort of faster and...I was *really* anxious and...I just really wanted to run out of the bus and I didn't want to be there so um but I couldn't even get up...and these were very much the very symptoms that the client was presenting to me in the sessions” (Charlotte, p. 6, line 142).

Karly talks about what it is like when her clients' issues touch on her own during a session. She describes how she has to consciously set her own concerns aside so as to make herself more emotionally available for her clients. My impression is that Karly's enhanced self-awareness demonstrates her clinical capacity to be more available to her clients and to be involved in her clients' unique experiences:

“...when I work with clients around issues around food there is *a lot* that comes up: issues around weight, constructions around body image, um, I have to be yeah I have, I have to be quite mindful that I have thoughts and sometimes it’s a really deliberate bracketing off while I’m sitting as a therapist. I have to go, ‘that no—that’s for another time’” (Karly, pg. 14, line 341).

Dorinda also talks about what it is like when her clients’ issues touch on her own. However, her reference to the ‘fast-paced’ nature of her CBT service seems to support her sense of difficulty in making room for the implicit emotions that arise in relation to her client ‘that CBT doesn’t have space for’. Nonetheless, her differentiation between ‘a difficult client’ and ‘a client’s difficulties’ that affect her seems to signify her openness to being affected by her clients and her capacity to take responsibility for her own ‘being’ in her clinical practice:

“If I have a difficult—not a necessarily difficult client but a client that their issues, whatever they are, really, really touch me in...an emotional way...I would, uh, yeah, would find it really difficult afterwards because, again, this is a very fast-paced service” (Dorinda, p. 5, line 112).

Seeking balance

Most participants described the difficulty of balancing the experience of just ‘being’ they received in their own therapy with the more active, ‘doing’ framework of the CBT model they were applying in clinical practice. Six out of the seven participants seemed to find a balance by incorporating aspects of self-reflection and emotional attunement as a foundation for their clinical practice. This appeared to illustrate their use of ‘being’ as a base from which to ‘do’ their clinical work. It was as if this implicit ‘use of self’ served as a supplement to the explicit templates of participants’

clinical protocols. Participants' capacities to relate their clinical work as therapists to their personal therapy as clients seemed to translate into their capacities to relate to their clients and to work together to provide a congruent therapy.

For example, Hank speaks about the internal balance he achieves from his personal therapy, which serves to benefit his clinical practice. It appears that Hank's experience in his own therapy translates into the 'cognitive' and 'goal-driven' focus of his clinical practice by 'refreshing' his ability to be self-aware and mindful:

"So maybe the balance of, um, me working cognitively, um having the personal therapy that's not goal-driven, allows it to be balanced...it allows me to be very refreshed and very, um, uh, present in, in, in the sessions with my clients. So yeah, personal therapy gives me that, the ability to be very conscious and real within my sessions" (Hank, p. 20, line 435).

Charlotte recounts the first time she had experienced the healing capacity of empathic, 'non-doing' in personal therapy, an experience that, like Hank, now translates into her clinical practice. It seems that, prior to her own experience of therapeutic empathy, Charlotte had not realised its absence from her protocol-led clinical practice in which she saw therapy as an activity designed to 'do' and 'fix':

"I really underestimated the power of empathy...I just wanted to *do* things, fix things, you know, working with things and have an issue and solve it...But I think it wasn't until then that I experienced pure empathy in a very, very therapeutic, um, way (Charlotte, p. 11, line 253).

Dorinda similarly speaks about her role or, even, 'rule' as a therapist to involve both her capacities for symptom treatment and emotional containment. In the subtheme,

‘Making room for emotional experiencing’, she reflects on her clients’ implicit feelings of anxiety that seems to extend beyond the scope of the goal-driven CBT model she follows. Whilst there does not appear to be room for these implicit feelings within the explicit templates of her clinical practice, Dorinda appears to make room for them within herself:

“I would be more containing and more patient ‘cause, ‘cause I see my rule, my role is not just treating a disorder but also being a space for the anxiety and to be contained” (Dorinda, p.16 line 352).

Karly discusses the significance of using both implicit and explicit communications in her clinical practice to provide well-informed interventions. She exercises her capacity to balance her implicit reactions with explicit reflections, demonstrating her direct acknowledgement of that which is indirectly expressed. This appears to illustrate how Karly balances ‘being’ and ‘doing’ within her clinical practice:

“I have a particular client who likes to know that I’ve remembered their history...And sometimes I will choose to give them that that acknowledgement...And there are other times when I think I’ll, I’ll perhaps just reflect on, on what they’re doing...I wonder what’s happening that they’re feeling the need to seek reassurance that I’ve remembered something” (Karly, p. 24, line 586).

DISCUSSION

This chapter discusses key findings in relation to relevant theoretical literature. Consistent with an IPA model, participants' experiences of internal conflict and of 'being human' are discussed and contextualised through a philosophical framework. This follows with clinical implications for training, theory, and practice in CBT. The reflective considerations and delimitations of this study are then addressed with suggestions for further research. From the analysis presented in the previous chapter three master themes have emerged: 'Personal Therapy Creates Conflict', 'Personal Therapy Ties Me to Humanity', and 'Personal Therapy: Being and Doing'. Potential implications of these themes are explored in the sections below.

Personal Therapy Creates Conflict

All participants referred to their experiences of personal therapy in a way that seemed to create conflicts in their clinical work. It seems important to consider that all participants had only experienced personal therapy of a different model to CBT, except for one, who had undergone CBT briefly but had more experience of personal therapy of a different model. An important distinction can be made between 'personal therapy' per se and the particular model of therapy that was experienced by participants. It can be argued that long-term exposure to a model of therapy (from personal therapy or otherwise) that is different to the one in which one has been trained is likely to potentially interfere in the way one thinks and practices. Yet, it was participants' sense of dubiousness about integrating aspects of their personal therapy into their clinical practice that stood out. Recall that Dorinda describes her clinical work as: "...completely almost pure CBT protocol but really influenced by just a little

tiny bit of psychodynamic thinking that...I gained from looking at my own processes...in my own therapy, what I re-enact from the past” (p. 5, line 101).

In another example, Peter states, “Now some would say, ‘this is a disaster, that doesn’t do the trick’. Um but I tend to feel this helps clinical practice...So you could say, from a rigid CBT point of view, it’s led me astray” (transcript 1, p. 8, line 151). It was the aspects of their own therapy that participants found most helpful that seemed, at the same time, to be the very aspects that were most painfully at odds with their professional identity as CBT therapists.

In ‘Working in the shadow of what CBT should be’ participants spoke about how their personal therapy equipped them with therapeutic tools that paradoxically hindered their capacity to practice ‘pure’ CBT: a seemingly clean and uncontaminated clinical template against which their rather messier personal therapy experiences intruded, and about which they seemed to feel guilty. Most participants shared a sense of clinical wrongdoing, as if under pressure to practice CBT ‘purely’, which, consequently, appeared to sponsor their experiences of conflict with the CBT model.

Accounts suggested that being a CBT therapist meant adhering to one standard without the space for individuality and flexibility. ‘Protocol versus exploration’ and ‘Practice versus preach’ further drew attention to striking differences between the therapy participants sought and the therapy they delivered. For example, Dorinda states “I don’t go to therapy from a sort of mental health crisis point of view. I go to therapy as a way of self-discovery” (p.11, line 239). Yet, it was their very use of personal therapy for self-discovery that seemed to support their sense of connection to their clients; enhancing their capacities to relate to others.

‘Self and other’ helped illuminate participants’ experiences of being in relation to their clients. Participants spoke about how their personal therapy served to enhance self-awareness, to familiarise them with their own feelings, and to facilitate their capacities to share themselves with their clients in order to be a part of their clients’ clinical experiences. Accounts suggested that personal therapy facilitated a space for individuality and flexibility fundamental to their clinical practice. Although perhaps messier, participants’ capacities to ‘use the self’ to take responsibility for their own feelings and vulnerabilities appeared to strengthen their capacities to tolerate the feelings and vulnerabilities of their clients.

A dilemma in the field of psychology

Participants’ experiences of conflict between their personal therapy and clinical practice can be broadened to a dilemma in the field of psychology in which the prevailing political culture seems to dismiss the therapist’s ‘use of self’ in place of ‘pure’ and ready-made solutions; prioritising adherence to treatment strategies over the relational components of clinical theory and practice. Gabriel Marcel’s existential theories (1949, 1951, 1963a, 1964a) offer insight into this rise in technology and techniques and its overall dehumanizing effects, within which our inherent need for connection becomes a collection of internal conflicts and dilemmas. Gabriel Marcel’s philosophical perspective seems to penetrate the essence of participants’ experiences, illuminated in the sections below.

Gabriel Marcel

Gabriel Honoré Marcel (1889-1973) was a French existential philosopher who gave significant consideration to the factors of constructive and meaningful relationships within a technologically dehumanizing society. In his philosophical writings, Marcel (1964a, 1965) invites us as humans to be ‘present’ with one another, rather than becoming objects for each other. His philosophy has scarcely been incorporated into the research literature of the helping professions and, therefore, it seems appropriate to briefly introduce Marcel to the reader before drawing on his key ideas to enrich participants’ accounts.

Marcel’s preoccupation with human existence emerged alongside his existentialist contemporaries, such as Paul Ricœur, Emmanuel Levinas, Simone de Beauvoir and Jean-Paul Sartre, amongst others. Yet, he was particularly influenced by the Christian philosophy of Søren Kierkegaard (Malagon, 2016). Raised atheist, Marcel’s fascination with religious dimensions of life led to his conversion to Christianity at the age of 40. Due to spiritual differences, Marcel and Sartre quickly became rivals. Sartre’s atheistic views on the reality of God and philosophy of the isolated self as detached from the outside world (Sartre, 1943/1992) conflicted with Marcel’s concern for experience over abstraction (i.e. he felt God and, therefore, God existed; Marcel, 1951) and belief in the inherent ‘participation’ between self and other (Marcel, 1949). Marcel’s (1949, 1951, 1964a) philosophy, alternatively, shares many parallels with Jewish philosopher Martin Buber (1878-1965; 1923/1970) both of whom found that our capacity to understand the essence of another’s experience is embedded in our capacity to connect with another and to ‘participate’ in the other’s experience.

The term ‘mystery’ was used by Marcel to describe the insights that arise from our ‘participation’ with others (Marcel, 1965). However, Marcel (1964a) warned that the world of science inherently supports an objective perspective of problem-solving through which human ‘mystery’ is easily dismissed. The conflict between personal therapy and clinical practice experienced by participants resonates with Marcel’s (1949, 1963a) theory of how our growing reliance on technology and techniques can serve to deny the presence of ‘mystery’ by allowing only that which techniques can address: the problematic.

Problem versus mystery

It appears that the field of psychology has become easily influenced by the rise of treatment protocols, and is becoming increasingly dominated by a science of quantitative methodologies and objective outcome measures that serve to translate the subjective aspect of treatment into formulaic techniques or procedures—if not to deny its existence altogether. Recall Raul’s distinction between ‘mainstream’ CBT and his clinical practice: “I regard CBT as the application of evidence-based protocols to specific problems. That isn’t my definition of therapy. I see therapy as a much more of an exploratory operation” (p. 4, line 72). Participants highlight a major thread of Marcel’s (1952) philosophy that raises the issue of protecting one’s subjectivity from annihilation within a technology-driven society. Marcel recognised the benefits of technology, however, warned of a ‘technological mindset’ where people are considered as *something* to be manipulated and exploited, rather than being considered *someone* with whom to engage and participate.

Participants distanced their CBT practice from the standardised, protocol-led CBT ideal they perceived, which seemed to reflect the value they placed on exploring their clients' mysteries, rather than following a more 'mainstream' CBT model: where human problems become standardised and are meant to be solved similarly from person to person with a technique that, arguably, could be employed by anyone (Treanor & Sweetman, 2016). For example, Dorinda recounts the dehumanising effects the medical model of mental health treatment can have on both client and therapist: "...they come in, and they go *woosh* 'Here's all my stuff, you deal with it.' And and then you kind of diagnose and, and you treat...Doctor my foot is hurting" (p. 14, line 342). In speaking about her clinical practice, Dorinda raises the issue of becoming a problem-solver.

Marcel (1952) was critical of science for its dehumanizing effects, as well as, its focus on solving problems. A 'problem' is a question that is meant to be answered objectively and in which, consequently, the identity of the questioner becomes irrelevant. In contrast, a 'mystery' represents a process of exploration and meaning-making, which, consequently, invites the questioner to subjectively participate, facilitate, and be touched by 'the other' experience (Marcel, 1963a). Once the object of a problem is understood or solved, it is considered complete, whereas a mystery always remains alive and interesting (Marcel, 1949). More importantly, and embedded within this research project, a 'mystery' is a question in which I, as the researcher, am intimately involved.

Science versus philosophy

My close connection with this research project compares with participants' accounts of their intimate involvement in clinical practice: there were times I felt it was necessary to 'go off track' from the interview schedule in order to stay with participants' experiences. As Charlotte recounts: "...if I continued with my structured sort of way...I would've completely overlooked [my client's] needs and what was so alive in the room" (p. 15, line 360). However, at first, this can be challenging. My internal sense of pressure to be a 'scientific-practitioner' as I conceived it, presented an internal dilemma as if I had to choose between adhering to a method and allowing myself to be led by, and to relate to, participants. My experience further resonated with Peter's experience of relying too heavily on protocols: "I appear at times mechanistic, and I've sometimes thought, *oh god I didn't really relate to that person at all*" (transcript 1, p. 21, line 435). Following my first and second interviews, I acknowledge my dilemma in supervision and came to realise that my position as a 'relational-practitioner' was significant to my research and could be drawn upon to enrich my role as 'scientist-practitioner'.

Marcel (1952) reminds us that the application of scientific knowledge requires complex negotiations within the uniqueness of encounters. The current state of reliance on empirical outcomes conveys a sense of needing to 'prove' or 'cure' something, which undermines the significance of unique experiences and its phenomenological insight. In support of Marcel's (1952) philosophy, Treanor and Sweetman (2016) argue that experience is not an object and, therefore, cannot be viewed objectively.

Evidence versus reflection

Evidence-based practice emerged in psychology as an attempt to improve clinical outcomes by getting clinicians to base their choice of interventions on empirical evidence rather than clinical impression, intuition, and convention (Sackett & Rosenberg, 1995). However, this positivist approach sacrifices our consideration for the uniqueness of being. We see here a ‘technological mindset’ (Marcel, 1952) that applies to people, where we consider ourselves and others in terms of the various functions we perform: in terms of the evidence we produce. What we risk ignoring is the fundamental dignity of each individual person, a kind of mysterious worth at the centre of each human being which cannot be easily summed up or defined (Marcel, 1952), and which we can begin to learn about from our own self-reflections. Recall Karly’s demonstration of reflections that she uses to guide her interventions: “I’ll think, *what’s my motivation? Am I trying to prove that I’m a good therapist? In that moment, what’s going on for me? Am I feeling vulnerable? If I’m feeling vulnerable, is it my vulnerability? Is it their vulnerability?*” (p. 24, line 597).

The relevancy of self-reflection in mental health science has been a long-standing debate. Eysenck (1949) proposed that self-reflection is not appropriate to science and encouraged a more objective, methodologically sound, impartial and scientifically acceptable approach. Marcel (1952) argued that this scientific egoism has the capacity to replace ‘the mystery of being’ with a false scenario of human life composed of technical ‘problems’ and ‘solutions’. For example, Raul stated: “...working to a, to the formula...doesn’t have the same components that, uh, the work that I would seek to do, which is to help people understand who they are” (Raul, p. 12, line 241).

Participants' accounts seemed to suggest that the CBT ideal undermines the complexity of their clients' realities, which is precisely where their use of self-reflection is paramount: to acknowledge and tolerate the distress of their clients that extend beyond the expected. Raul described the significance of his personal therapy in this regard: "...I was really wiped out by it. Um, I just felt completely...annihilated by the process, um, and [personal therapy] was very helpful because I was able to put it into place and to think, well, you know, *what was actually going on?*" (Raul, p. 23, line 472). Rather than control the direction of the therapy, participants seemed to prefer to facilitate the therapeutic process, to embrace the mysteriousness of the therapeutic encounter and allow the unexpected to arise. However, at times, these aspects of participants' clinical practice were overshadowed by their sense of expectation to stick to the manual with concern for what their 'institutional supervisor' might say.

As experienced therapists, most of whom practice privately, participants' expectations and concerns appeared to illuminate an internal dilemma between adhering to protocols and allowing for more spontaneous emotional responses. Marcel (1963b) suggested that techniques help us maintain a sense of control by keeping us within an objective position and protect us from the vulnerability and responsibility that arises when we subjectively relate to others. The process of problem-solving can be objective, detached, in search of immediate clarity, to elicit a rapid resolve (Lantz, 2004). On the other hand, the process of mystery, of exploration and meaning-making, invites participation, facilitation, subjectivity and the ability to be touched by another's distress. The dilemma that participants talked about concerning their model seemed to nourish the already difficult feat of human connection and of being deeply

affected by the client's process. However, their experiences of personal therapy appeared to elucidate this dilemma and to facilitate participants' capacities to value and navigate the difficulty in getting emotionally involved with clients and feeling connected.

Personal Therapy Ties Me to Humanity

All participants spoke about their feelings and vulnerabilities as a 'normal' and important part of 'being human'. In 'Manifesting empathy' participants' accounts suggested that their familiarity with their own vulnerabilities and emotional sensitivities facilitated a process of empathy by which participants and clients could share a common ground. Bringing their own 'mysteries' to personal therapy seemed to serve to strengthen participants' sense of self and, consequently, to enhance their sense of presence in clinical practice. Recall Karly's example of 'Manifesting empathy' when a client's issues touched on her own:

“...the client wanted to just end...and I said, *no...you're going to come back and we're going to look at this, and we're going to reflect and understand and be together in this ending... we're not going to do what always happens in both their life and my life*” (p. 10, line 235).

Through personal therapy, participants appeared to develop a sense of familiarity with their own emotional distress that conveyed a level of comfort mirrored in their clinical practice, with which they seemed able to tolerate the emotional distress of their clients. Marcel's (1964b) notion of 'presence' illustrates this level of clinical participation as a shift from being external to becoming internally involved with

another—an achievement from the more common tendency to remain a stranger to oneself and, consequently, to others as well.

Presence

Accounts suggested that participants' experiences in personal therapy, of becoming deeply involved with and open to themselves as human, facilitated their capacity to be present with their clients. For example, Hank stated, "As a therapist or as being a human being, I think if ...you understand and own your own stuff you can be more open with other people the same way you can be with a client (p. 12, line 247).

Marcel (1964b) linked openness and intersubjectivity with achieving 'presence' by which one allows oneself to be moved by the other, a mysterious and enlightening experience, a vitalising source of cognition, that gives life and strength to our encounters (Marcel, 1964b). Participants' experiences of clinical presence seemed to convey deep and meaningful encounters where they could enter into the presence of their clients through their own individual presence (Marcel, 1964b). Recall Sandra's experience: "And I have it out not to engineer and interrupt because I have been through that experience and I recognise the importance of their need to cry...and that's okay and my being silent and that's okay" (p. 12, line 266).

My 'presence' as a researcher similarly depended on my capacity to connect with participants, to meet them where they are, and be open to the mysteries that arose from our encounters. I was afraid that by 'being' a part of the discussion, I would risk 'doing' the interview incorrectly. It appeared that some participants similarly feared that by taking part in therapy they could risk 'doing' CBT incorrectly. Recall that Sandra said: "It's probably hard to tell your supervisor, *I just let the person cry...*It's

almost like a, well you need to do more ...there are a certain set of expectations associated with what you achieve” (Sandra, p. 12, line 260). However, by being aware of and open to her own experiences of needing to cry, Sandra managed to set aside her sense of expectations to stay with her client’s experience.

My initial attempt to adhere to the interview schedule was part of my defence against the discomfort of allowing the unknown, with all its mystery and vulnerability, to arise. Marcel (1965) suggested that mystery precedes all our encounters, however, at first only unconsciously, which allows us to engage more impersonally. It then becomes our choice as to whether to embrace the unknowns within ourselves and the other, to develop a deep personal connection, or not, and maintain a more internally withdrawn position.

By drifting from the interview schedule, I acknowledged my fear of uncertainty, of not knowing what I am doing, from which emerged a deeper fear that I might be an incompetent researcher. I was tempted to avoid my fear and my associated sense of responsibility for participants. I was tempted to dismiss my sense of influence on the interviews and to ignore how I, too, was affected by each encounter. Instead, however, I chose to embrace my fear and sense of responsibility to engage in and develop each encounter; to facilitate an enriching and internally expansive process. Although at times painful, I worked hard to acknowledge my own sensitivities and vulnerabilities, which, in turn, served my capacity to be receptive to participants’ sensitivities and vulnerabilities. A reciprocal process emerged by which each encounter seemed to illuminate new aspects of ourselves and our experiences.

All participants similarly referred to ‘Recognising the client within’ and demonstrated a clinical capacity to recognise something in their clients after having encountered it within themselves. They felt that their positions as clients were essential to their clinical practice and offered them the insight they otherwise could not attain. For example, Dorinda stated: “And why I notice that blind spot, mainly because I’ve been there. I had, I’ve got my own blind spots” (p. 14, line 318). The ease in which participants spoke about being like their clients seemed to support a notion of common humanity. However, ‘being human’ also seemed to include vulnerabilities and problems that, as therapists, they felt they should not have.

In ‘Holding both positions as therapist and client’ it appeared that the emotional distress participants considered ‘normal’ for humans was, as therapists, an Achilles heel and engendered feelings of shame. Recall when Peter said, “It’s just a bit of my life that hasn’t been quite normal. I mean it’s normal to be fucked up but, you know, it’s not the normal thing you’ve, I think you’d expect counsellors to have had” (transcript 2, p. 6, line 137). Participants raised the issue of a double standard between what was appropriate for them to feel as clients (or humans) and as therapists, respectively. However, their experiences as both client and therapist seemed to bridge this gap and to sponsor a clinical experience in which two humans could share a therapeutic space.

The importance of being human

All participants spoke about the importance of ‘being human’ and the fundamental connection it helped forge between them and their clients. Allowing themselves to be similar to their clients seemed to translate into a clinical common ground, where two

humans could share a therapeutic space. Yet, in moments of ‘being human’, like their clients, participants struggled with the conflict of their positions as therapists, as if they could not be both. Recall that Charlotte feared to be similar to her client: “...she was depressed, and she started talking about her struggle....as she was talking I, I just had this moment of panic, like, *god she’s describing me!*...And then I think I really panicked...how can I help her when she’s describing *me* as her *problem*” (p. 9, line 204). As the researcher of this project, I experienced this double standard through the notion of ‘navel-gazing’ that, at times, overshadowed my research. I was introduced to this term at the suggestion that, rather than focus on the perspectives of therapists, I focus my research on the perspectives of clients. The fact that the participants of this research project are clients seemed to be dismissed.

‘Navel-gazing’ seems to represent a movement within the psychotherapy professions by which therapists have been accused of participating in excessive introspection at the expense of their clients. However, the notion of navel-gazing perhaps also serves to undermine the very process through which participants felt they learned to ‘be’ therapists and ‘be’ human. Recall when Peter said, “My early years were very sort of isolated...and full of awkward emotions like shame...and, so CBT comes along and provides a very explicit template, which enables one to actually say, *well this is how emotions happen*” (transcript 2, p.1, line 23). Although Peter had not undergone CBT himself, his ability to draw from his own experiences seemed to facilitate his sensitivity as a therapist to his clients’ emotional difficulties and the great relief therapy can offer.

Marcel (1956) suggested that it is only through the discussion, exploration, understanding, and reflection of the unknown parts of ourselves that we can begin to discover our intentions, adaptability, and freedom to respond to life in a variety of ways; and to facilitate a similar process of self-discovery in others (Marcel, 1956). This is a spiritual process that observes a quality of concern with the human soul and a quest for meaning, purpose, and value within ourselves, and to acquire insight into our own character (Swinton, 2001). As it relates to and affects the human spirit, the most valuable contribution to achieving such deep human connection is the self.

The use of self

In ‘Maintaining a space within’ participants spoke about their ‘use of self’ in a way that appeared to illustrate this process of self-discovery through which they could temporarily offer, or ‘dispose’ of, themselves for the use of their clients (Marcel, 1964a). As Raul stated, “It’s the use of the self. And the more you are aware of how you are as a person, I think, the more you are aware of how the other is as a person and the more you can see what’s going on for the other” (p. 28, line 583). This ‘use of self’ appeared to convey participants’ shared sense of commitment to go outside of themselves to respond sensitively, respectfully and generously to the values and needs of their clients and expressions of desire for meaning (Pembroke & Pembroke, 2008). Buber (1923/1970) added that this spiritual element also serves to reduce isolation by facilitating the experience of being part of a larger whole. Marcel (1963a) further identified loneliness as human’s ultimate source of suffering, which we overcome by allowing ourselves to connect with others from a place deep within ourselves.

All participants spoke about a therapeutic space within themselves that they reserved for their clients, which appeared to convey a mental space of psychological hospitality and of emotional holding, where participants were capable of offering clients support. For example, recall Dorinda's experience: "'Cause I'm kind of aware of my own suffering, but I'm also aware of the person who's coming suffering. 'Cause I spoke about my own suffering in my own therapy....so I'll have a lot of space for that'" (Dorinda, p. 17, line 374). This appears to illustrate a bidirectional process of exploration and discovery in which participants involved themselves, and looked within themselves, to develop a fuller understanding of their clients. Marcel further developed this process within his notion of 'secondary' reflections: deep reflections that begin at the edge of our self-awareness (Marcel, 1951).

Primary versus Secondary reflections

The use of the self is what distinguishes Marcel's (1951, 1952) 'primary' and 'secondary' reflections. 'Primary' reflections serve a specific function, to examine objects through an analytical breaking down of 'it' to a technical solution. Recall how Charlotte had initially viewed her clinical practice: "I wanted to *do* things, fix things, you know, working with things and have an issue and solve it" (p. 11, line 256). In contrast, 'secondary' reflections involve the use of that which is within 'me' and serves to develop a fuller understanding of the mysterious by considering how we might also influence the situation. For example, Karly describes her own clinical practice as: "...absolutely pivotal in challenging my own issues, my own relationship with...Anxiety, depression, mood, eating, you know, all the different aspects that come in through the door" (p. 6, line 138). Participants similarly reflected on their clinical experiences by involving themselves as equal contributors, exploring the

simultaneous existence of both their clients' and their own unique experiences. They appeared to acknowledge their unknown selves and, therefore, could seek ways to participate more fully in the unknowns that would arise in their clinical practice (Marcel, 1963a).

Participants spoke about their use of personal therapy as a way to embrace their life's many mysteries and to open themselves up to establish a deep connection with their clients. For example, Dorinda reflects on how personal therapy helps her make sense of her clinical experiences and states, "...I just kind of make sense of it in therapy...it's not just about me...it's me wanting to discuss whatever touched me but at the same time, uh, having the client in mind (p. 6, line 120). Hank similarly describes his experience of positioning himself by his clients to help him participate in his clients' experiences: "...my personal therapy would help me to, to be okay with the reality of where my clients are at...it's sort of normalising life and not making it, um, this big scary thing" (p. 17, line 369). This opening up of the self expands on the spiritual quality of relationships discussed earlier, based on a profound level of empathic emotional exchange. Although participants did not appear to engage in a back-and-forth of emotional sharing with their clients, they seemed to offer their clients a space within themselves to help manage the intense feelings too difficult to bear on one's own.

In line with Marcel's philosophy, Bazanno (2016) emphasises the significance of a therapeutic space that goes beyond narrative, where interactions can flow between therapist and client—the full meaning of which is often mysterious and beyond conscious thought. This focus on the therapeutic process helps highlight participants'

experiences of clinical participation, where they could begin to share and sense their clients' understanding of what it is like to be them (Bazzano, 2016).

Although narrative, or content, is useful and provides therapists with important information regarding the functional reference points they need to follow to know *what* the client is experiencing, 'process' uncovers *how* the client is experiencing: revealing affect and other aspects of the self that are not readily accessible through discourse but, rather, through the exploration of a less conscious awareness (Bazanno, 2016). Participants referred to moments in their clinical practice when they experienced enhanced insight into their clients' emotional experiences by sharing the client's feelings or taking on the client's feelings themselves, which served to facilitate a deeper understanding of the clinical process beyond a relational dimension. Recall when Hank describes his experience of working through his client's anxiety: "...I took on [my client's] anxiety, and I brought that to therapy to sort of look at that...that's where therapy will help you or help me sort of move forward, um, where I can just go, *okay let's just pull the bones out of something*" (p. 20, line 424). Participants' capacities to offer their clients the most within dimensions of themselves appeared to enhance their sense of emotional attunement, as well as their capacity not to get entangled in the relational, to maintain a simultaneous connection and separation with their clients (Bazzano, 2016). Marcel's (1951) notion of 'disponibilité' further elaborates on this 'use of self'.

Disponibilité versus Indisponibilité

The notion of 'disponibilité' describes someone who is prepared to put themselves at the disposal of another; to loan oneself to another based on one's inner available

resources (Marcel, 1951, 1964a). The concept of ‘disposing’ oneself to another involves the capacity to temporarily remove one’s thoughts and feelings from an encounter to offer the whole of oneself as an empty space for another to temporarily inhabit. This appears to inversely resonate with the significance of participants’ personal therapy by which the extensive process of self-discovery served to enhance their self-awareness in clinical practice and to make use of themselves in ways adaptable to the individual needs of their clients. For example, Karly describes ‘bracketing off’ her own ‘frame of reference’ to “stay with the client...in terms of how do they understand it, how they make meaning, what is the significance in their life?” (p. 6, line 136). Participants appeared to convey a shared sense of clinical generosity by which they tolerated their own availability and disposability; exposing themselves to the influences their clients could potentially have on them; and remaining permeable to those influences, to provide space for their clients within themselves (Marcel, 1963a).

Marcel (1950) used the term ‘chez toi’, directly translated as ‘your house’, to portray the human capacity to offer internal hospitality: to be receptive and ready to open oneself to another; to make one’s soul available to another; and to provide an empty space within oneself to be temporarily filled by another’s uniqueness, needs and desires. Participants appeared to illustrate a similar sense of availability within themselves to encourage clients to discover themselves freely, facilitating within themselves their client’s own self-discovery. In contrast, ‘indisponibilité’ refers to someone who relates to others on functional and technical terms, kept at arm’s length and reduced to ‘examples’, ‘cases’ or ‘he/she/it’ (Marcel, 1964a). An indisponibilité encounter involves the collection of ‘data’, gathering information on the aspects of a

person that serves to complete a ‘form’, or formality. Similar to the notion of ‘problems’ described earlier, the unique identity of the person under question is dismissed and, therefore, the identity of the questioner is also dismissed. Its impersonal nature makes both parties replaceable (Marcel, 1964a).

Marcel (1964a) utilised the term ‘avec’, of which the literal meaning is ‘with’, to emphasise the human necessity of participation within a relationship, to be affected by one another, due to our inherent desire to share ourselves *with* another. Like Hank stated, “You are building a relationship with a client because they’re sitting there with you and are about to, um, sort of pour their hearts out and tell you their life story” (p. 11, line 227). The way we affect one another is not always pleasant. Participants’ accounts included painful experiences of distress that arose within their clinical practice. Recall Raul’s experience of “annihilation”, Charlotte’s experience of “panic”, and Hank’s experience of anxiety, following their sessions with clients. Yet their openness to bear the difficulties that arose in their therapeutic relationships seemed to demonstrate their sense of fidelity towards their clients and the therapeutic process.

My disponibilité as a listener to participants’ stories similarly required that I acknowledge and set aside my own experience to focus on and explore how participants understood their experiences, how they made meaning of them, and what significance it had in their lives. Yet it was only through the use of my own experience that I could explore and understand their experiences. I had to draw from my own similar experiences to differentiate myself from participants. Encountering participants in this way meant that I had to tolerate my discomfort with the unknown

and fears of ‘doing’ it wrong, and perhaps it was in the safety of my own vulnerability that I implicitly gave permission to participants to talk about their discomfort, vulnerabilities, and fears. Furthermore, perhaps it was their open expression that has given me permission to more fully express myself here. Tolerating our uncertainty together meant embracing the uncertainty of where our exploration could go, which facilitated our capacity to allow ourselves to go somewhere new.

Marcel (1951, 1956, 1963b) similarly referred to the notion of fidelity to describe one’s availability to another that can withstand the difficulty and unpleasant feelings that might arise and to illustrate our creative capacities, described earlier. Fidelity requires an active willing of ourselves to be open and permeable towards another and to the influx of the other’s presence (Treanor & Sweetman, 2016). Participants’ accounts of managing the uncertainty and confusion that arose in their clinical practice appeared in their perception of clients, not as a set of characteristics or symptoms but, rather, as people with whom they identified and participated in the therapeutic journey.

Accounts suggested that by drawing on their own vulnerabilities, participants could better understand and tolerate those of their clients and, furthermore, could value their own problems and vulnerabilities as avenues through which they forged fundamental connections with their clients. Yet, when speaking about their experiences of ‘being human’ with their clients, issues were raised about how these experiences could be integrated with the ‘doing’-focused framework of their CBT clinical practice.

Personal Therapy: Being and Doing

Results suggested that, for most participants, there appeared to be a fundamental divergence of attitude between the space for ‘being’ offered in their personal therapy and the emphasis on doing in their clinical practice. However, as therapists, participants seemed to rely on their capacities to integrate a space for ‘being’ within their goal-orientated CBT model to offer their clients a more flexible and individualised therapeutic experience.

Participants’ accounts seemed to convey their experiences of CBT as too greatly focused on task-centred techniques at the expense of deeper self-exploration (Marcel, 1948, 1963b, 1964a). Recall that, in contrast, Peter explained: “If they don’t want to go a particular way, I’m very easy going about that. That doesn’t worry me. *You don’t have to do this procedure, let’s just talk*” (transcript 1, p. 7, line 134). Giving space for exploration and emotional expression is conveyed by Marcel (1951, 1956) as giving ‘testimony’, which is believed to facilitate genuine communication and human exchange; a clinical process valued by participants. The distinctions between ‘problem’ and ‘mystery’, ‘primary’ and ‘secondary’ reflections, ‘disponibilité’ and ‘indisponibilité’, each of which expand onto the next, further develop into the disparity between ‘observation’ and ‘testimony’ (Marcel, 1973).

Observation and Testimony

To participate in ‘observation’ is to engage in a functional approach to facilitate the clarity of knowledge in which one objectively reports on another’s patterns of cognitive and behavioural sequences (Marcel, 1964a, 1973). Although it is considered important to identify and assess human patterns of behaviour that inhibit growth and

development, Marcel (1948, 1963b, 1964a) argued that treatments centred on maintaining objectivity run the risk of facilitating an emotional distance through the use of techniques meant to instil a task-centred approach to treatment. Similarly, in ‘Making room for emotional experiencing’ participants spoke about going ‘off track’ from their clinical protocol to prioritise their clients’ emotional needs. For many participants this appeared to present them with a predicament in which they had to choose between following the CBT model or their clinical intuition; between ‘observation’ and ‘testimony’. Participants spoke about CBT as a model of conscious reasoning and explained that, when they allowed themselves to drift away from conscious reasoning, their clinical intuition served to facilitate their capacity to be more present in their clinical practice. For example, Charlotte found that the CBT model’s priorities to take action and challenge thoughts, at times, worked against her capacity to provide “...the space for a person to just be and, um, to just accept, you know, rather than trying to distract themselves or run away from it or correct their thoughts or their pattern of behaviour.” (p. 12, line 283). Accounts further suggested that participants shared a sense of willingness to encounter, empathise, and engage in order to ameliorate a distance and avoidance of connection (Marcel, 1949, 1950); an element of ‘being’ that they seemed to adopt from their personal therapy.

Participants spoke about their experiences of ‘Being present’ as intricate moments of deep thoughtfulness, in which they tuned into their own experience while simultaneously ‘attending’ and ‘attuning’ to their clients’ experiences. Recall that, when speaking about his clinical practice, Hank referred to tuning into his own experience as a client to stay with and participate in his client’s experience:

“...I have one client in particular...he comes in here
and...he’s already, he’s had his session...So I have to bring

him back to right now to where we are *right now*...And so for that to happen I also need to be present and focused. So that's when my personal therapy comes in. It helps *me* to be there and do that" (p. 43, line 512).

Testimony represents a subjective approach to knowledge that utilises internal availability and fidelity to observe the impact of the other on the self and the self on the other. Charlotte described a moment in her clinical practice when: "I sort of put all the paper and everything away and I just sat. And I um, and she cried, very much so, and she talked, um, and I felt that that's exactly what she needed there and then" (p. 15, line 354). This generous and genuine intersubjective encounter is meant to sponsor engagement, based on the process of enrichment rather than clarity, and describes a process of knowledge gained over time through reflections within an authentic relationship (Marcel, 1948, 1951).

Accounts suggested that participants integrated the notion of 'testimony' into their 'observation'-based practice by embracing opportunities to be present and available; to sponsor a fundamental connection with their clients based on their shared experience of being human (Marcel, 1951, 1964a). Giving testimony further appeared in participants' capacities to notice and honour the discovery of the unknown within themselves and their clients, facilitating a parallel movement from unconscious to conscious levels of awareness. For example, Karly considered the significance of "...when I work with clients around issues around food there is *a lot* that comes up...while I'm sitting as a therapist. I have to go, *that no—that's for another time*" (p. 14, line 341). Karly's enhanced self-awareness, and ability to set her concerns aside, appears to demonstrate her clinical capacity to be more available to her clients and to be involved in her clients' unique experiences.

Participants' involvement in their clinical practice implied more than a protocol-driven notion of therapy; drawing from their own experiences as a means of 'Participating in the therapeutic process'. Charlotte recounted a similar experience of being receptively present: "...I start noticing that my hand starts sweating and...my heartbeat was sort of faster and...I was *really* anxious... and these were very much the very symptoms that the client was presenting to me in the sessions" (p. 6, line 142). Marcel's (1963b) notion of 'presence' discussed earlier, along with Buber (1965), help further illuminate how being open to their own self-discovery served to facilitate participants' capacities to allow themselves to be touched by their clients and to explore the ways in which they were affected by them. As Dorinda described it, when "a client that their issues, whatever they are, really, really touch me in...an emotional way...I would, uh, yeah, would find it really difficult" (p. 5, line 112).

Testimony can only occur through the committed presence of one to another, and through maintaining the relationship in spite of the difficulties, suffering and pain that can arise from revealing the true nature of oneself through human connection (Marcel, 1963b, 1964a). All participants spoke about their sense of involvement in their clinical practice, conveying their openness and willingness to be affected by their clients. It seemed that by drawing from their own problems and vulnerabilities they could allow themselves to personally and emotionally connect with, and relate to, their clients in order to attain a more profound understanding of their clients' experiences. Their openness and willingness to meet their clients in this way, to 'be human' with their clients, appeared to serve as the foundation upon which participants practiced CBT.

Marcel's philosophical insights all come back to the notion of 'problem vs mystery', the issue of protecting one's subjectivity from annihilation within a technology-driven society (Marcel 1952); and perhaps it is important here to question how alien the notion of 'problem vs mystery' appears to be within the dominant, rationalist framework within which much of psychology resides, and upon which CBT is based. Recall how Charlotte described her initial experience of working with the CBT model, "I just wanted to *do* things, fix things, you know, working with things and have an issue and solve it" (p. 11, line 253). In speaking about their clinical practice, participants raised concerns with their evidence-based framework due to its focus on 'problem'-solving and dismissal of their more subjective participation in uncovering 'mystery'. It appears that the significance of human connection is being replaced by science and its preference for ready-made solutions. This was further articulated by Sandra's struggle to 'make room for emotional experiencing' in her clinical practice: "It's probably hard to tell your supervisor, *I just let the person cry for the entire fifty minutes*. It's almost like a, *well you need to do more...to move towards the goal of using their scores...*there are a certain set of expectations associated with what you achieve" (p. 12, line 260). This raises contentious issues concerning CBT theory, training and practice.

Implications for CBT Theory, Training and Practice

Marcel's philosophy helps illuminate how participants made sense of their experiences of using personal therapy in their CBT clinical practice. It emphasises the importance of being human, of acknowledging what makes us human and of tolerating our humanness. All participants spoke about using their personal therapy as

a way to relate to, and connect with, their clients. However, the value of their experiences appeared to be overshadowed by the CBT model they followed and its promise of a standardised, ready-made solution. Paradoxes emerged: the aspects of personal therapy participants found useful in their clinical practice clashed with their identity as CBT therapists; and the value of their position as clients revealed emotional difficulties that, as therapists, they feared they should not have. These contradictions have potential implications for CBT theory, training and practice, which are discussed in the sections below.

CBT theory

There appears to be a split between the human and mechanistic theoretical foundations of CBT. Roth and Pilling's (2008) competence framework for CBT acknowledges a comparable gap between CBT as an art and as a science and uses the term 'metacompetences' to refer to the capacities required to apply the science-based therapy artfully: in a flexible and individually tailored way. 'Metacompetent adherence' is meant to bridge science and artistry together to deliver more effective therapy by using evidence-based adaptations of CBT techniques to respond to human experience with humility, compassion, and openness to learning whilst delivering the best evidence-based intervention that one can (Roth & Pilling, 2008). As I reviewed the literature, I could not help but wonder, what is evidence-based humility?

CBT seems to be trying to empirically validate the therapeutic relationship and is struggling to do so because it is hard to measure. Its metacompetence consists of numerous procedural rules for applying CBT in different specific circumstances (Whittington & Grey, 2014). These metacompetences presumably lay the foundation

for attending to the therapeutic relationship, “to create the right interpersonal context to carry out the tasks of CBT” (Kennerley, 2014, p. 31).

This presents a purist paradigm where the therapeutic relationship is considered a competence that is based on what one sees: visible and measurable phenomena. This seems to create conflict: a split from the fundamental mystery and unknown of human experience. In speaking about their clinical practice, participants raised the issue of feeling conflicted between the importance of human connection and the evidence-based priorities of their clinical practice.

The therapeutic relationship

Initially grounded within a psychodynamic perspective, Beck promoted the CBT model with consideration for the therapeutic relationship (Beck, Rush, Shaw & Emery, 1979) and employed the term ‘working alliance’ or ‘therapeutic collaboration’ to describe “the general characteristics of the therapist that facilitate the application of cognitive therapy,” which include “warmth, accurate empathy and genuineness” (Beck et al., 1979, p. 45). In comparison to Roger’s (1957) necessary and sufficient core conditions of empathy, congruence and unconditional positive regard, the ‘working alliance’ in CBT is considered necessary but insufficient for optimum therapeutic effect (Beck et al., 1979). Therefore, relationality seems to be conceptualised and understood within the CBT model as a necessary condition in which protocols must be followed.

The quality of the therapeutic relationship has become increasingly formalised through quantitative evidence that supports its use as an important element of

successful treatment, to predict therapeutic compliance and outcome (Martin, Gorske and Davis, 2000; Orlinsky, Grawe & Parks, 1994; Orlinsky, Rønnestad and Willutzki, 2004), even with internet-based treatment (Knaevelsrud & Maercker, 2007). Indeed, Knaevelsrud and Maercker (2007) found that high client-ratings of the therapeutic alliance and low drop-out rates indicate that a positive and stable therapeutic relationship can be established online. In light of the empirical evidence, there has been increased interest in the nature of the therapeutic relationship in CBT (Bennett-Levy and Thwaites, 2007; Gilbert, 1992; Gilbert and Leahy, 2007; Greenberg, 2002; Leahy, 2001, 2005; Safran, 1998; Safran & Muran, 2000). Today, the British Association for Behavioural and Cognitive Psychotherapies (BABCP) recognises its relevance as a criterion of accreditation: requiring practitioners to demonstrate knowledge and understanding of the therapeutic relationship, and competence in the development, maintenance and ending of the therapeutic relationship (<http://www.babcp.com/files/Accreditation/CBP/Full/CBP-Full-Guidelines-V7-230516.pdf>).

There have been empirical attempts to identify the ‘micro skills’ underlying better therapeutic relationships, such as ‘active listening’, ‘regulating’, and ‘differentiating and attending’ (Gillespie, Smith, Meaden, Jones and Wane, 2004; Ivey and Ivey, 2003; Rollnick, Mason and Butler, 1999; van der Molen, Hommes, Smit and Lang, 1995). However, these skills may often be overlooked in CBT training due to the model’s emphasis on techniques, which are thought to be sufficient for change (Leahy, 2008). Prized as an empirically supported treatment, the CBT model risks allowing the therapeutic relationship to be altogether foreshadowed by techniques and protocols.

CBT training

There is a current trend in which technical expertise is prioritised over relationality, where ‘doing to’ overrides the relationship in which ‘being with’ a person is paramount (Strawbridge, 2003). Marcel (1964a) suggested that deep human connection is embedded within our openness to explore that which is mysterious and difficult to understand within ourselves. The more we participate in our own self-discovery, the more we can connect to others, and the more we connect to others the more in touch we are with the richness that develops from our participation (Marcel, 1964a). This cyclical process helps illuminate how participants used personal therapy in clinical practice: to maintain a balance between ‘being’ and ‘doing’ in their clinical practice.

Bennett-Levy, Thwaites et al. (2009) recommend the use of self-practice and self-reflection (SP/SR) over personal therapy, as an integrative training strategy to ‘fine-tune’ the delivery of CBT protocols (Thwaites, Bennett-Levy, Davis & Chaddock, 2014). SP/SR is aimed at therapists who have achieved competence in CBT and wish to move towards developing therapeutic artistry from the ‘inside’ (Bennett-Levy, Travers, Pohlman & Hamernik, 2003). SP/SR is meant to enhance therapists’ capacities to apply evidence-based protocols with greater sensitivity, flexibility and finesse (Thwaites et al., 2014). However, in comparison to participants’ accounts of embracing the many mysteries of self and other through the therapeutic relationship, SP/SR is promoted as a way to overcome working with “clients that are so depressed that we find ourselves getting sucked into their sadness and hopelessness,” because, “Unfortunately, being a competent CBT therapist does not automatically lead to the instant transfer of evidence-based approaches to ourselves!” (Thwaites et al., 2014, p.

241). All participants spoke about investing in their own self-discovery to enhance their sense of connection with their clients, open to the unknown ways in which one influences the other, to explore the mysterious aspects of the therapeutic relationship. In comparison, and in line with the evidence-based priorities of the CBT model, SP/SR appears to create an instrumental view of relationality that, ultimately, serves to problematize intersubjectivity.

Alternatively, participants appeared to share a sense of intersubjectivity that illustrated a spiritual element, beyond the physicality of manuals and protocols, by which they could relate to clients on a profoundly emotional level and could tolerate their encounters with clients in a way that allowed them to be, in turn, affected. It seemed as if participants were following their own code of clinical behaviour, guided by the ethical foundations revealed, explored and developed within themselves. This internal code of conduct appeared to serve the foundation upon which participants practiced CBT. Yet, the aspects of intersubjectivity they found useful to their clinical practice were the same aspects that clashed with their identity as CBT therapists.

CBT practice

The priority of evidence-based CBT practice has been a logical extension of the tradition of the clinician-scientist who seeks to ground clinical practice in research (Norcross, Beutler & Levant, 2006). However, there has become a growing need to balance the longstanding position of scientific practitioners with an understanding and use of a more reflective practice (Galloway, Webster, Howey & Robertson, 2003). This split is comparable to the dilemma of ‘problem vs mystery’ that emerged from participants’ experiences: of having to choose between practicing CBT as scientific

‘observers’, objectively reporting patterns and behaviours, or as a reflective ‘presence’, subjectively seeking mutual humanity (Buber, 1965).

Bennett-Levy and Thwaites (2007) recommend the use of the SP/SR training tool to integrate the CBT model’s technical and relational components: to bring the ‘person of the therapist’ into the ‘self-as-therapist’. However, this suggests that the starting point is mechanisation: a level of competency that then seems to try to integrate the human into the mechanical procedure of applying protocols and techniques. It seems as if CBT therapists are not meant to start as humans or therapists, but as mechanised performers who then have to become more personal. This mechanised version of humanity gives credibility to Marcel’s (1949, 1951, 1963a, 1964a) warning of the rise in technology and techniques and its overall dehumanizing effects.

It appears that the human subject struggles to exist in this mechanised world and, instead, becomes replaced as a human object with particular functions (Marcel, 1949, 1952, 1963a). There is an element of safety in becoming objects for each other, where evidence-based practice can manage and guide an, otherwise, complicated decision-making process. Rationalising the complexity and uncertainty of each unique therapeutic encounter can be appealing (Kirmayer, 2012). Moreover, our reliance on techniques can serve to maintain our sense of control and to protect us from the vulnerability and responsibility that arises when we subjectively relate to others (Marcel, 1963b). Similarly, one might follow idealised forms of therapy to protect oneself from one’s own ‘humanness’ (Fotaki, 2006).

Accounts suggested that participants used personal therapy to expose their humanness, no longer making it ‘this big scary thing’, which they could then translate into their clinical practice. In this way, personal therapy seemed to help participants ‘be’ human and ‘be’ therapists and served as a foundation upon which they practiced CBT: sponsoring fundamental connections with their clients based on the shared experience of being human.

Being human

A fundamental aspect of participants’ experiences of clinical practice seemed to be the nurturance and acceptance of their humanness and, consequently, of their clients’ humanness. It appeared that through their own therapy participants discovered less of a need to hide. In fact, accounts suggested that participants’ need to hide was due to their shared sense that, as therapists, they should not ‘be human’. Wilson, Weatherhead and Davies (2015) explored the personal therapy experiences of trainee clinical psychologists, who are predominantly trained in CBT, and similarly revealed the presence of stigma by which participants sensed shame in their roles as clients; and considered their personal therapy to be, in part, a weakness; as if, as therapists, they were expected to be ‘more sorted’ (p.11).

In moments of being human participants struggled with their position as therapists, as if they could not be both. It seemed that the uncertainty and vulnerability that emerged from their accounts of clinical practice were easily dismissed by the evidence-based priorities of their CBT practice. Marcel’s philosophical insights urge us to embrace the mysteries of human connection: to stop being objects to one another and, instead, become subjects with each other (Marcel, 1952). Participants similarly

described participating in their clinical practice through their subjective offering of the self in order to share the emotional life of their clients. Their clinical participation seemed to increase their knowledge and awareness of both their clients and themselves, each reflected in the humanness of the other.

Participants described the significance of their personal therapy in their CBT clinical practice as an enriching and internally expansive process. Their capacity to be aware of their own presence and the presence of their clients, and to engage with both their clients' and their own participation in the therapeutic process, seemed to establish the context in which change could emerge. It has been suggested that CBT therapists believe that their interpersonal behaviour with clients can have a significant impact on the course and outcome of treatment, and have begun to accept personal therapy as a helpful way to improve clinical practice (Geller, Norcross & Orlinsky, 2005).

Bennett-Levy, Thwaites et al. (2009) argue that, in comparison to SP/SR, personal therapy is typically a longer and deeper process from which personal tensions can emerge without necessarily having clinical implications. Indeed, Marcel's philosophy of human connection is described as a collection of personal tensions. Participants' accounts suggest that, despite and in light of these tensions, personal therapy is a worthwhile process.

Implications for Counselling Psychology

Participants highlight a split in the psychotherapy professions between medical and humanistic approaches to therapy; between evidence-based priorities and expectations of reflective practice. Accounts suggest that seeking a balance between these approaches can lead to tensions and contradictions that seem to make them

incompatible. Counselling psychology resonates with this dilemma, which draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology (British Psychological Society, 2015). However, it is becoming increasingly difficult to integrate deep personal connection, to allow for our own humanness, within the medicalised and manualised priorities of NHS mental health care and its scientific approach to the therapeutic relationship.

The value placed on human connection during the therapeutic encounter is one of the fundamental tenets of counselling psychology (Woolfe, 1990) and yet there are ongoing debates about whether counselling psychologists can maintain their philosophical values within the growing medicalised culture (Larsson, Brooks and Loewenthal, 2012). There currently remains strong conviction that its humanistic underpinnings are what connects counselling psychology to a human science, which will continue to serve to challenge the prevailing medical model of mental health, the sentiments of reductive models of psychological healthcare, and the research-directed manualisation of psychological therapies (Strawbridge & Woolfe, 2010). Participants highlight the use of personal therapy to integrate the significance of becoming human into the medicalised approach to mental health treatment; to inspire a humanistic foundation upon which evidence-based therapy can be practiced.

Counselling psychology supports the use of personal therapy as a fundamental element of becoming a therapist, yet the prevailing push for evidence-based practice within the NHS seems to make personal therapy less relevant. However, if CBT, the ‘gold standard’ for the evidence-based movement in psychotherapy, claims to be a

relational approach to therapy, then a self-reflective process is important and requires the therapist to engage personally in the client's experience. Participants highlight the significance of their personal therapy in becoming human: in exposing their 'humanness' and in sponsoring the human connection upon which their clinical practice is based. Their accounts remind us of the importance of self-exploration and meaning-making to encourage participation, facilitation, and subjectivity within clinical practice and, perhaps more importantly, to allow ourselves to connect with and be touched by our clients' experiences. Gabriel Marcel's theoretical insights can be useful in understanding the significance of being human and of human connection in clinical practice, which can further be drawn upon in support of the philosophical foundations upon which counselling psychology is based.

Delimitations

This section discusses the potential delimitations of this research study, mainly drawing upon Smith, Flowers and Larkin's (2009) methodological guidelines. IPA was chosen for this research study due to its appropriateness to the research aim. It allows for the provision of a rich and complex insight into the subjective experience of the significance of personal therapy in CBT clinical practice. This study does not aim to determine a definitive or causal relationship between personal therapy and clinical practice, nor to provide generalizable results. Instead, this study aims to provide a detailed account of the experiences of a specific group of psychotherapists who practice CBT and have undergone personal therapy.

It can be argued that a small sample was a limitation. However, such a sample size is considered appropriate to the idiographic nature of IPA and the suitability of this

method for the investigation of the research question. Participants of this study are not, and were not intended to be, a statistically representative sample of CBT therapists. However, participants were selected to increase the homogeneity of the sample. From participants' accounts emerged a potential relevancy between personal therapy and CBT clinical practice, which contributes to an ongoing discussion amongst psychotherapy practitioners of the significance of personal therapy in clinical practice.

To increase the homogeneity of the sample I was careful to ensure that all participants shared a specific lived experience by including qualified practitioners who had over five years of post-qualification clinical experience and voluntary experience of a minimum of two years of weekly personal therapy. Despite this, the experiences of participants varied. A notable difference amongst participants pertained to the various models of their personal therapy.

All participants had undergone personal therapy of a different model to CBT (i.e. psychodynamic, Jungian, Humanistic, etc.), except for one participant who experienced brief CBT treatment in addition to a long-term therapy of a different model. Therefore, it could be argued that 'personal therapy' and 'theoretical orientation' have been conflated in this study and that a purer approach to the research question would be to carry out a study where there is consistency in the model of therapy the practitioner uses; or perhaps a consistency between the model of therapy the practitioner uses in their work and the model used in their personal therapy. Suggestions for future research can be to explore the perspectives of CBT therapists

who have primarily undergone CBT themselves or to explore the potential effects of each particular model of personal therapy on CBT clinical practice.

The use of semi-structured interviews represents another potential limitation: the researcher becomes the person in power by holding an agenda which might limit the interaction and steer it in a direction the participant might not have chosen otherwise (Potter & Hepburn, 2005). However, as discussed in the Methodology chapter, the reflexive element in which I, as the researcher, was tied to the research question was employed to minimise (although not eliminate) such impact. For example, I acknowledged an under-current in much of the language I used, which reflected my pre-existing beliefs and assumptions about the positive benefits and value of personal therapy. I had to monitor this closely and adapt my language to make it more neutral and open. Furthermore, this might have influenced the fact that all participants happened to report positive experiences of personal therapy. It would be interesting for future research to explore the experiences of CBT therapists who have not found personal therapy to be useful or helpful in clinical practice.

Another potential limitation concerns the subjective nature of the data collected and the researcher's interpretation of it. The data gathered reflects participants' experiences, understandings and beliefs, and are not trying to claim 'historical truth' or to represent an objective reality shared by all CBT therapists who have undergone personal therapy. Instead, the purpose of this research was to immerse the reader in the 'mystery' of participants' unique experiences of using personal therapy in clinical practice.

The notion of ‘problem vs mystery’ is embedded within this research project and supports ‘mystery’ as a question in which I, as the researcher, am intimately involved. This research project did not seek to solve a ‘problem’: a question meant to be answered objectively and in which, consequently, the identity of the questioner becomes irrelevant. On the contrary, the significance of this research project lies in the exploration of ‘mystery’ by which the questioner is invited to subjectively participate, facilitate, and be touched by ‘the other’ experience. Therefore, it seems important to draw upon my reflexive position to further explore my role in this study.

Reflexive Considerations

My personal motivation in developing this research was in my desire to marry the relational and positivistic elements of clinical practice. I have acknowledged my bias as a relational practitioner and struggle to integrate a standardised approach to clinical practice. I have revealed my perspective of the psychotherapy profession as split between the relational-practitioners and scientific-practitioners and sense of its growing division. My bias within this divide fuelled my underlying agenda to achieve a sense of unity, which undoubtedly served in the development of this study.

The recruitment process resulted in a selection of participants who all shared the belief that personal therapy is relevant to CBT clinical practice. In retrospect, my personal beliefs in the benefits of personal therapy manifested in my request for experience of at least two years of weekly personal therapy and served to attract a group of like-minded people. A person who had not found personal therapy to be beneficial would likely not have had such extensive experience of personal therapy.

Similarly, I developed the interview questions with this inclusion criteria in mind and focused on experiences of deep self-reflection.

My capacity to be neutral throughout the interview process was challenged by my belief in the significance of the therapists' use of self and influenced the interview process. The interviews were co-constructed based on the interaction between participants and me (Finlay, 2009), which was guided by and mirrored in our differences and similarities. My role as a trainee wanting to come across as a competent researcher appeared in participants wanting to come across as confident clinical practitioners and the more I acknowledged my own fears of being an incompetent researcher, the more a similar fear amongst participants seemed to emerge. Although I refrained from self-disclosure, my own subjectivity and interests had an inevitable impact on the interview process. My intersubjective approach to collecting data mirrored the intersubjectivity demonstrated by participants. How I listened to and interpreted participants' accounts were inevitably shaped by my own interests and subjectivity (Denzin & Lincoln, 2011). Although I tried to acknowledge and bracket my assumptions and expectations, the full extent to which I influenced participants accounts and my interpretation of their accounts remains unknown.

The influence of my personal motivation, bias, and agenda was made more apparent in my analysis presentation of the findings. The conflicts found in the data relate to my own experiences of conflict. The significance of 'being human' applies to a relational approach with which I take side. And the 'marriage' of being and doing resonates with my agenda to balance the relational and positivistic approaches to

clinical practice. However, despite my agenda, by the end of this research project, I found myself more biased than I had been at the start.

As demonstrated in my findings, my initial motivation to overcome my bias and achieve neutrality as a counselling psychologist has, instead, resulted in a sense of urgency to take sides and advocate for the significance of the therapists' participation and humanness in clinical practice. In line with my support for one's 'use of self', I find that my participation in this study has offered an invaluable perspective. Despite my desire to marry the relational and the positivistic elements of clinical practice, I found that it is difficult not to take sides in this deepening division in the profession. Indeed, the impossibility of remaining neutral is a significant finding of this research.

Conclusion

This study has illuminated a split in the psychotherapy profession and the tensions that arise from attempting to balance its deepening contradictions. The prevailing political culture has become strongly influenced by the seductiveness of ready-made solutions, which seem to compromise the significance of being human and of human connection in mental health care and treatment. In the current NHS climate, the therapists' use of self is being dismissed in place of manuals, tools and techniques, behind which the humanness of the therapist can easily disappear. The evidence-based priorities of the CBT model seem to mechanise humanity, undermining the enriching qualities of relationality and intersubjectivity within mental health research and practice. Through a relational and intersubjective approach, this study provides empirical evidence that supports the value of personal therapy in becoming human, in being a therapist, and in sponsoring human connection in CBT clinical practice.

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APPENDIX I – ETHICAL APPROVAL

The research for this project was submitted for ethics consideration under the reference PSYC 15/ 161 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 17 March 2015.

APPENDIX II – RECRUITMENT EMAIL



Are you a CBT therapist?

Have you had your own psychotherapy?

I am looking for accredited psychotherapists who have undertaken voluntary personal therapy on a weekly basis for a minimum of two years.

Can you spare an hour to talk about the relevance of your personal therapy to your CBT clinical practice?

Please see attached Participant Information Sheet. If you are interested—or know someone who might be— please contact me on: noblea@roehampton.ac.uk 07554882012.

Regards,

Ariele Noble

APPENDIX III – PARTICIPANT INFORMATION SHEET



Working title of Research Project: Is personal therapy relevant to CBT clinical practice? An interpretative phenomenological analysis.

What is the purpose of the study?

This Counselling Psychology doctoral thesis aims to explore whether, how and to what extent personal therapy might or might not be relevant to CBT clinical practice.

Why have I been invited?

You are invited to participate in this study because you have had both an accredited psychology/psychotherapy training and accredited CBT training, with at least five years of post-accreditation clinical experience, and voluntary experience of at least weekly personal therapy for a minimum of two years.

Do I have to take part?

Participation is completely voluntary with the option to withdraw at any time without giving reason.

What will happen if I take part?

You will be one of eight participants. Participation involves attending a one-hour audio- recorded, semi-structured interview, where you will be asked to discuss your experiences of how personal therapy has or has not been relevant to your CBT clinical practice. You can choose where you would like the interview to take place (either at the University of Roehampton, your private office or your home). You will have the option to review your individual transcript for accuracy and anonymity before it is written up in collated form. Results will first be written as a thesis for submission for a doctoral qualification (PsychD). It is further intended that this research will be published as a journal article.

Will my data be kept confidential?

Given the personal nature of the interviews, the information that you provide will be

anonymised to preserve confidentiality. There will be no identifiable information included in transcripts and you will not be identifiable in publication.

What are the benefits of taking part?

Participation can be beneficial as an opportunity to explore and reflect upon your own clinical practice.

Are there any potential disadvantages?

Following the interview you will have an opportunity to discuss anything you found difficult and you will also be invited to contact the Researcher for a follow up discussion should you wish to discuss things further.

What will I do if there is a problem?

If you have a concern about any aspect of your participation or any other queries please raise this with the Researcher or Director of Studies.

Researcher Contact Details:

Ariele Noble University of Roehampton Whitelands College Holybourne Avenue
London, SW15 4JD NobleA@roehampton.ac.uk 0755 488 2012

Director of Studies Contact Details:

Dr Rosemary Rizq University of Roehampton Whitelands College Holybourne
Avenue London, SW15 4JD R.Rizq@roehampton.ac.uk 020 8392 3000 ext. 5761

APPENDIX IV: CONSENT FORM



PARTICIPANT CONSENT FORM

Working title of Research Project: Is personal therapy relevant to CBT clinical practice? An interpretative phenomenological analysis.

This research study aims to explore whether and to what extent personal therapy is relevant to CBT clinical practice. This study is recruiting a total of eight participants who have an accredited psychology/psychotherapy training and accredited CBT training, at least five years post-accreditation experience, and voluntary experience of at least weekly personal therapy for a minimum of two years. Participation is voluntary and involves attending a one-hour audio-recorded, semi-structured interview where participants' experiences of how personal therapy has or has not been relevant to their CBT clinical practice will be explored. You can choose where you would like the interview to take place (either at the University of Roehampton, or your office or home).

Participants can potentially benefit from this study as an opportunity to explore and reflect upon their own clinical practice. Results will first be written up in a thesis for submission for a doctoral qualification (PsychD). It is further intended that this research will be published as a journal article.

Researcher Contact Details:

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Consent Statement:	Initial
I confirm I have read and understood the participant information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that if I disclose information about potential harm to myself or my clients the Researcher might have to breach confidentiality by discussing it with their supervisor.	
I understand that I am free to decline my participation of the study and I am able to withdraw from the study at any time without giving a reason, although if I do so I understand that my data might still be used in collated form.	
I consent to the audio recording of my interview.	
I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.	
I understand that relevant sections of the data collected by this research will be looked at by authorised persons from the University of Roehampton. Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project. All will have a duty of confidentiality to me as a research participant.	
I agree that I may be contacted in order to review transcripts for accuracy and anonymity.	
I agree that anonymised quotes from my interview may be used in any publications.	
I agree to take part in the above study.	

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the Researcher (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details:

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APPENDIX V – DEMOGRAPHIC QUESTIONNAIRE



DEMOGRAPHIC QUESTIONNAIRE

Age: _____

Gender: _____

Professional title: _____

Professional qualifications: _____

Year of qualifications: _____

Number of years of psychotherapy experience: _____

Years of voluntary personal therapy: _____

Theoretical orientation: _____

Number of episodes: _____

APPENDIX VI – INTERVIEW SCHEDULE

1. How long have you practiced CBT? Where were you trained?
2. What lead you to undertake personal therapy?
3. Do you feel that your personal therapy has influenced your CBT clinical practice? How or how not? Can you give examples?
 - a. Can you think of a time in clinical practice when you were aware of your personal therapy? In what way? Can you give examples?
4. Do you feel that that your personal therapy has been influential in maintaining effective therapeutic relationships? How or how not? Can you give examples?
 - a. Can you think of a time when working with client issues that have touched on your own? Was personal therapy useful? How or how not? Can you give examples?
5. Is there anything more you would like to talk about?
6. What has it been like to take part in this interview?

APPENDIX VII – DEBRIEF SCHEDULE



DEBRIEFING SCHEDULE

Participant ID number:

Title of Research Project: Is personal therapy relevant to CBT clinical practice? An interpretative phenomenological analysis.

Debriefing information:

1. Recap on purpose of the study:

This research study aims to explore whether and to what extent personal therapy is relevant to CBT clinical practice.

2. Review of interview:

Would you have liked anything done differently?

3. Follow up discussion:

You are invited to contact me for a follow up discussion if you wish to discuss things further.

4. Future concerns and contact information:

If you have a concern about any aspect of your participation or any other queries please raise this with the Researcher (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department.

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Head of Department Contact Details:

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Contact information for further support:

British Psychological Society (BPS) - 0116 254 9568, enquiries@bps.org.uk
British Association for Counselling & Psychotherapy (BACP) - 01455 883300,
bacp@bacp.co.uk
UK Council for Psychotherapy (UKCP) - 020 7014 9955, info@ukcp.org.uk

APPENDIX VIII – SAMPLE EXCERPT FROM ANNOTATED TRANSCRIPT

250	D04 14: Yeah, yeah yeah. It was. I was. And sometimes	Need for ‘release’
251	I’m quite attuned to the client’s need for that release. Uh	Offering the client what she received
252	and even though I also practice CBT uh here in uh	
253	private practice rather than in an NHS setting, so I don’t	Difference between private practice and NHS
254	have—many of my clients come through the insurance	
255	route so I do have a limitations in terms of the number of	Significance of time
256	sessions but most insurance companies are quite	
257	generous in that they provide up to 12 sessions uh, which	Need to ‘achieve’ ‘significant benefits’
258	is quite a a good number of sessions to achieve uh	
259	significant uh benefits for the client. Uh whereas now in	
260	the NHS they work with four or six sessions in the CBT	Focus on the client’s wants
261	model and you know, of course, then if the client is	
262	distressed and they may want—need the entire session	A conflict between a need for ‘release’ and need to ‘achieve’;
263	just to cry about because they are distressed. You know,	between client and therapist;
264	as a CBT therapist in an NHS setting you would feel	
265	limited to the extent that you you can’t tell your—it’s	between therapist and supervisor.
266	probably hard to tell your supervisor, <i>I just let the person</i>	
267	<i>cry for the entire 50 minutes.</i> It’s almost like a, <i>Well you</i>	Internal supervisor
268	<i>need to do more,</i> [laughs] sort of, <i>to move towards the</i>	Standardised practice vs. flexibility
269	<i>goal, of using their scores at the end,</i> and you know	
270	whatever there are a certain set of expectations	Flexibility is to recognise the need of the client
271	associated with what you achieve in the first session and	
272	the second session, etcetera, even if it’s too prescribed. I	Giving what she received
273	don’t have, of course I have a sort of model of where I	
274	want to get to with the client but I’m more flexible in	Comfortable with veering off agenda
275	that I will recognize the need for if the client needs to	
276	cry fffor 50 minutes. That’s okay. And have it out not to	
277	engineer and interrupt um because I have been through	
278	that experience and I recognize the importance of their	
279	need to cry for for for 50 minutes and that’s okay and	
280	my being silent and that’s okay. So I’m more	
281	comfortable, I’ comfortable with that. And I guess I I	

282	have more freedom in the private practice since I	Disclaimer: I do
283	practice here to to engineer therapy in the way that I	not work for the
284	think would be beneficial to the client rather than being	NHS, means
285	too worried about what my supervisor um institutional	freedom to
286	supervisor might say to me or tell me I haven't fulfilled	individualise
287	certain goals, um for example.	therapy to the
288	Interviewer 15: You've brought up this very	client, mixed with
289	individualized processes.	a sense of clinical
290	D04 15: Hm, that's right. Yes, yes I guess I guess even	wrong-doing
291	though CBT is a small structured form therapy in	Structured
292	comparison to person-centred and perhaps	AND
293	psychoanalytic um...I think the personal experience that	Individualised
294	personal therapy has—and also the type of therapy of	Personal therapy
295	CBT that I trained, the particular institution where I	and CBT training
296	trained, and the people that trained me um...the	emphasised
297	emphasis was on individualized case formulation	individualised
298	approach to the work with clients. So—as opposed to the	approach
299	manualised, protocol based CBT, so the importance of	Manualised
300	formulating the the cli the eh problems with the clients	opposes
301	was at the core of understanding how to work with the	individualised
302	clients. So I feel that um personal therapy um has	How she relates
303	influenced that sort of part especially to do with uh	to clients'
304	building the trust in the relationship with the client so	problems
305	that I can understand well their problems and then use	influences how
306	the psychological theory and mechanisms to then explain	she works with
307	the maintenance of the problem or um or to propose the	them?
308	treatment for their difficulties. So yes I guess um it is a	Personal therapy
309	quite an individualized way of working with clients.	develops capacity
310	[Pause] From a CBT perspective because it is...um	to build trusting
311	influenced and I do follow sort of protocols for, I dunno,	relationships;
312	what you do for panic disorder, how you treat someone	influences how
313	with OCD but um well probably it's ver always very	she relates to
314	case individualized.	clients; enhances
		her understanding
		of clients.
		Integrates
		individualised
		personal therapy
		with CBT
		'mechanisms'

APPENDIX IX – SAMPLE INDIVIDUAL ANALYSIS

Theme 1: Being human - “You know, you’ve got to be kind of human” (Raul, page 29, line 591).

In linking personal therapy and clinical practice Raul focuses on the significance of *being human* and his use of personal therapy to enhance his *humanity*. He states, “I don’t quite understand how um why one would deny oneself that important contribution to *really* enhancing your humanity” (Raul, page 28, line 572). Raul’s use of the terms *human* and *humanity* appear to illustrate a common ground between therapist and client, of human nature, in which people make use of others. Raul is both client and therapist. His experiences as a client implicitly link to his experiences as a therapist and suggest a parallel therapeutic process by which two unlike people meet in a similar way. Raul states, “...everyone’s different, everyone’s the same. And so there’s the sameness which underpins it” (Raul, page 14, line 293).

Subtheme: Surrendering to difficulty - “...I dealt with it in personal therapy because I was really wiped out by it. Um, I just felt completely uh um uh um annihilated by the process um and that was very helpful because I was able to put it into place and to think, *well*, you know, *what was actually going on?*” (Raul, page 23, line 472).

Subtheme: Learning from misunderstanding - “And I was thinking about it afterward and thinking about it with my therapist and I was thinking that the body language was total serenity...I couldn’t see that she was uh in *huge* amounts of stress and in working through that um I uh uh have become uh uh very alert to um body language and um and I sometimes uh will ask someone who looks serene what they’re actually feeling” (Raul, page 23, line 480).

Subtheme: Exposing himself to another - “...people are talking to me all the time. And I find it an enormous relief to be able to go somewhere and actually talk about myself for an hour. I know that might be my uh um um need for visibility um but it doesn’t really matter. Uh um it’s a just strikes me as immensely important uh for a well-rounded uh person” (Raul, page 20, line 415).

Theme 2: Distinguishing self from other - "...the most important thing is the ability to distinguish self from other" (Raul, page 17, line 344).

Raul appears to appreciate the similarity between therapist and client, which further serves to highlight his capacity to recognise differences between himself and his clients. He commends his personal therapy for enhancing his self-awareness, which, in turn, enhances his awareness of others' differences; to be able to think about and experience himself and others as different. This suggests that personal therapy facilitates Raul's capacity to utilise self-awareness and make use of himself to better understand his clients' individualities.

Subtheme: Deliberating between what is going on for him and what is going on for his clients - "It is the use of the self. And the more you are aware of how you are as a person, I think, the more you are aware of how the other is as a person and the more you can see what's going on for the other" (Raul, page 28, line 583).

Subtheme: Differentiating between his experience as a client and the experience of his clients - "I am very validating and I'm aware that my therapist isn't validating...and I've been thinking about her absence of explicit validation...and I've been thinking about what extent my explicit validation um might actually prevent uh in my clients uh their self-validation. Or to what extent my specific validation actually contributes to their self-validation" (Raul, page 9, line 180).

Subtheme: Making a distinction between his feelings and his clients' feelings - "...I have some clients who are very very silent uh and uh so I will sometimes say to them um um uh, *This session seems quite silent, what are you feeling?* Um because I don't know what they're feeling but I know that I'm feeling anxious" (Raul, page 24, line 499).

Theme 3: Making a distinction between CBT and his clinical practice - "...I suppose it's the reflective self" (Raul, page 12, line 245).

When describing his therapeutic approach, Raul makes distinctions between traditional CBT practice and his more reflective and relational practice. Raul states, "...the function of the therapist is...to be able to ask questions and to elucidate and...to make statements which increase understanding uh and the relationship itself can do that" (Raul, page 13, line 272). When making distinctions between CBT and his clinical practice he talks about his "reflective self", gained from personal therapy, which enhances his therapeutic "arsenal". When discussing his experience as a client with different therapists he states, "...they've all given me something...by collecting insights it gives me uh uh uh wider arsenal uh to be useful to the variety of client that one sees. If you only have a hammer everything is a nail" (Raul, page 17, line 337).

Subtheme: Protocols vs. Exploration - "But I don't really regard CBT as therapy. Um I regard CBT as the application of evidence-based protocols to specific problems. That isn't my definition of therapy. I see therapy as a much more of an exploratory operation. Much more exploratory on how you work and how you fit together" (Raul, page 4, line 72).

Subtheme: Working to a formula vs. Helping people understand who they are - "But that's really working to a to the formula...and if that's your target and that's your goal, which is absolutely legitimate and nothing nothing wrong with it um uh then that's what you do but uh uh uh it's not it doesn't have the same components that uh the work that I would seek to do, which is to help people understand who they are" (Raul, page 12, line 241).

Subtheme: IAPT vs Psychotherapy - "If you're an IAPT person...you're not really doing psychotherapy. Uh and so I I'm not sure you would need um um to be in...I'm in personal therapy for richness...I'm not working on any particular um um uh uh traumatic issue apart from life" (Raul, page 20, line 409).